A QUASI EXPERIMENTAL STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTUERD TEACHING PROGRAMME ON THE LEVEL OF KNOWLEDGE REGARDING DEMENTIA AMONG ELDERLY IN A SELECTED VILLAGE AT TIRUPUR.

BY

301231852

A DISSERTATION SUBMITTED TO THE TAMILNADU Dr.M.G.R. MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN NURSING

OCTOBER – 2014

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SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN NURSING FROM THE TAMILNADU Dr.M.G.R. MEDICAL UNIVERSITY, CHENNAI.

OCTOBER – 2014

DECLARATION

I hereby declare that the present dissertation titled "A quasi experimental study to assess the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in a selected village at Thirupur District outcome of the original research work undertaken and carried out by me, under the guidance of Research Guide Prof. **Mrs.M.KAVIMANI, R.N,R.M, M.N**, Principal, Shivparvathi Mandradiar Institute of Health Sciences, College of Nursing and the Clinical Specialty Guide **Asst.Prof.Mrs.JOTHIMANI, R.N,R.M,M.S.N.**

I also declare that the material of this has not found in any way, the basis for the award of any degree/ diploma in this University or any other University.

301231852

CERTIFIED THAT THIS IS THE BONAFIDE WORK OF

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THIS STUDY IS DEDICATED TO

MY BELOVED FAMILY

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"Be strong and take heart, all you who hope in lord"

"God will make a way where there seems to be no way"

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301231852

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LIST OF ABBREVIATIONS

SHORT FORMS	ABBREVIATION
SPMIHS	Shivparvathi Mandradiar Institute of Health Sciences
STP	Structured teaching programme
H_1	Research hypothesis
MSC (N)	Master of science in nursing
P	Probability
F	Frequency
%	Percentage
χ^2	Chi-square test
SD	Standard deviation
NS	Non Significant
MD	Mean Difference
AD	Alzheimer's Disease
AAFP	American Academy of Family Physicians
CT	Computerized Tomography
PET	Positron Emission Tomography
EEG	Electro Encephalogram

ABSTRACT

A quasi experimental study to assess the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in a selected village at tripur. Tamilnadu was under taken by 301231852 as a partial fulfillment of the requirement for the degree of Master of Science in nursing at Shivparvathi Mandradiar Institute of Health Science, under the Tamilnadu Dr.MGR Medical University during the year 2012-2014.

The objectives of the study were;

1. To assess the pre test and post test level of knowledge regarding dementia among elderly in experimental group and control group.
2. To evaluate the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in experimental group.
3. To find the association between the post test level of knowledge on dementia and the selected demographic variable among elderly in experimental group with their selected demographic variables.

The research hypotheses formulated were;

1. There is a significant difference between the pre test and post test level of knowledge regarding dementia after STP among elderly in experimental group.
2. There is a significant difference in post test level of knowledge regarding dementia among elderly between experimental group and control group.
3. There is a significant association between the post test levels of knowledge on dementia and the selected demographic variables among elderly in experimental group.

The investigator organized the review of literature under three sections as follows; Studies related to incidence and prevalence of dementia, Studies related to knowledge and awareness of dementia, and Studies related to effectiveness of structured teaching programme.

The conceptual framework for this study was based on Nursing Process model developed by ANA (1991).The research design used was a quasi experimental design. Study was conducted among 60 elderly, 30 elderly in experimental group and 30 in control group who were selected by purposive sampling technique in palayakottai at tirupur (Dt).

The data collection tools were validated by 2 psychiatrists, 3 nursing experts and 1 visual engineer. The tool developed and used for data collection was a structured knowledge questionnaire method. Reliability was established by test retest method r=0. Pilot study was conducted among 10 elderly in archuna nagar at nathakadaiyur.

Main study was conducted in palayakottai at tirupur (dt). After the pretest structured teaching programme was conducted for elderly in experimental group and then post test was conducted. Data obtained were edited, organized, analyzed by using SPSS (Version 13) and interpreted by descriptive and inferential statistics. The findings revealed the effectiveness of structured teaching programme.

The findings of the study showed that there was a significant ($p<0.05$) improvement on level of knowledge regarding dementia after the structured teaching programme among experimental group. There was no significant association between level of knowledge and selected demographic variables in experimental group. The conclusion of the study was that structured teaching programme was an effective method for improvement of knowledge on dementia among elderly.

The limitations, implications and recommendations were adequately spelt.

CHAPTER I

INTRODUCTION

BACKROUND OF THE STUDY

"You have to lose your memory if only in bits and pieces
to realize that memory is what makes our lives.
Life with memory is our reason, our feeling,
and our action, without it we are nothing."

Demographic aging is a global phenomenon with differential impact on world regions. It began early in developed countries and progressed over longer period of time and they had more time to develop services. Regions like Asia, Latin America and Africa are now witnessing rapid demographic aging and the developing countries in this region will have comparatively little time to develop geriatric services. It is this unprecedented pace of demographic aging which makes it such a huge public health challenge for the region. Though the biological phenomenon of aging is universal, the daily life of an older person varies considerably according to social, economic, and cultural contexts. Aging and health has many socio-cultural determinants. Social status and available social support for older people vary in different cultures. In many developing countries, older persons are accorded with great respect, both within the families and in society.

Dementia in the elderly is called senile dementia or senility, and viewed as a normal and somewhat inevitable aspect of growing old, rather than as being caused by any specific diseases. It becomes more common with age. While only 3% of people between the ages of 65–74 have dementia, 47% of people over the age of 85 have some form of dementia. As more people are living longer, dementia is becoming more common.

Dementia is a broad category of brain diseases that cause long term loss of the ability to think and reason clearly that is severe enough to affect a person's daily functioning. It develops when the parts of the brain that are involved with learning, memory, decision-making, and language are affected by one or more of a variety of infections or diseases. The most common form of dementia is Alzheimer's disease (75%). Other forms include Lewy body dementia, vascular dementia, fronto-temporal dementia, progressive supra-nuclear palsy, cortico-basal degeneration, normal pressure hydrocephalus and Creutzfeldt–Jakob disease.

Dementia is the most feared and divesting disorder of late life. Current estimates reveals that there are about 18 million cases of dementia in the world and by 2025, there will be about 34 million suffering from dementia. The overall prevalence of dementia ranges from 5 percent to 7 percent. Alzheimer’s disease is the most common demanding disorder accounting for 80 percent of all cases of dementia

Dementia is not merely a problem of memory. It reduces the ability to learn reason, retain or recall past experience and there is also loss of patterns of thoughts, feelings and activities. Additional mental and behavioral problems often affect people who have dementia, and may influence quality of life and the need for institutionalization. As dementia worsens individuals may neglect themselves and may become disinherited, the individual may become incontinent as their condition worsens. Depression affects (20–30%) of people who have dementia, and about (20%) have anxiety. Psychosis and agitation/aggression also often accompany dementia.

As the disease stage progresses to the middle stage, patients might still be able to perform tasks independently, but may need assistance with more complicated activities. In the late stage patient will not be able to perform even the simple tasks independently and will require constant supervision. They may eventually to lose the ability to swallow food and fluid and this can ultimately lead to death.

There is currently no cure for the disease. Currently available medications offer relatively small symptomatic benefit for some patient but do not show disease progression. It helps a little for the memory. The sun will continue to show its rays on the world. The waves of the vast ocean will continue their rush to reach the shore and the wind will continue to blow the leaves of the tree.

But let us all accept the patient with Dementia and give them a better tomorrow.

NEEDS OF THE STUDY

Dementia is characterized by loss of or decline in memory and other cognitive abilities and reduces the lifespan of affected people. In 2005, it was estimated that 24.3 million worldwide and 1.8 million people in India are affected with dementia. In India the number of people with Alzheimer's disease and other dementias is increasing every year because of the steady growth in the older population and stable increment in life expectancy and it is expected to increase two-fold by 2030 and three-fold by 2050. Dementia is often associated with physical, mental and financial burden and evidence suggests that elderly people with dementia in developing countries do not often utilize health care services, and when they do, the health care system is often ill prepared to provide quality services for dementia. Around 10-37% of the elderly population with dementia in developing countries is classified as having potentially vulnerable living circumstances with requiring long-term and specialized care. Despite mortality due to communicable diseases, poverty and human conflicts, dementia incidence is destined to increase in the developing world in tandem with the ageing population.

According to the Alzheimer's disease International (ADI) Delphi consensus study, by 2040 71% of people with dementia will be living in developing countries. It is estimated that there are about 1.5 million people with dementia in India

(compared with 2.9 million in the USA).This number is likely to increase by 300% in the next four decades. This estimate is based on the premise that the Indian incidence rates are relatively low and will remain stable over time. The relatively high prevalence of smoking and the high and rising prevalence of type 2 diabetes are matters of concern in India. These coupled with anticipated life style changes could affect the incidence rates and lead to a higher than expected prevalence in the near future. The levels of caregiver strain, including that contributed by behavioral disturbances and stress are as high as in developed countries despite extended family networks and home care. Dependency, moreover, is strongly linked to poverty, and imposes additional economic strain on families. People with dementia are cared for at home, by their families. Most families cannot afford institutional care, which in any case is, unavailable in most parts of the developing world.

It is estimated that over 3.7 million people are affected by dementia in our country. This is expected to double by 2030. It is estimated that the cost of taking care of a person with dementia is about 43,000 annually; much of which is met by the families. The financial burden will only increase in the coming years. The challenge posed by dementia as a health and social issue is of a scale we can no longer ignore. Despite the magnitude, there is gross ignorance, neglect and scarce services for people with dementia and their families. We know that dementia is not part of aging and is caused by a variety of diseases. We now have a range of options to treat the symptoms of dementia and offer practical help to those affected.

The ‘Dementia India Report’ is an ambitious visionary document calling for government and policy makers to recognize dementia as a health and social welfare priority by developing a National Dementia Strategy. The report has been put together after a series of consultations across the country from January 2009 to March 2010. The editors have used these consultations and the data available from the findings of the 10/66 Dementia Research Group worldwide, the ADI’s World Alzheimer Report 2009and from other research in India. In Indian context prevalence of Alzheimer’s disease is one in every five elderly Citizens suffer from Alzheimer’s. In Kolkata there

are about 46,000 patients with Alzheimer's. In Delhi it accounts for about 50,000 Alzheimer's patient and in Bangalore there are 30,000 elderly patients suffering from Alzheimer's disease. Today in India 32, 00000 people are affected by dementia. The figure is expected to double every 20 Years.

According to Dr. Harlem (2012) Tomorrow's elderly people are today's adult and Yesterday's children. Adulthood is a unique phase of human development. Adults are the important feature of every society and also a great resource of a nation. Life expectancy has gone up from 20 years at the beginning of the 20th century to 62 years today. India has a large segment of older people in the population. This segment is growing fast with the rapid increase of the grey population in India. Indian aged population is currently the second largest in the world. By 2020, of the countries with the largest elderly population in the world, five will be in developing world, China 230 million, India 142 million, Indonesia 29 million, Brazil 27 million, and Pakistan 18 million. India is home to more than 70 million people older than 60 years as per the 2001 Census. This age group, only 7.5% of the population in 2001, is expected to grow dramatically in the coming decades. With demographic ageing comes the problem of dementia. The numbers of persons with dementia double every 5 years of age and so India will have one of the largest numbers of elders with this problem.

In developed countries, dementia awareness is growing rapidly, with the media playing an important part. Recent evidence-based reports from the UK and the Australian Alzheimer associations garnered considerable media attention and were instrumental in making dementia a national priority in both countries. Public awareness in low and middle income countries is lacking, with few media outlets carrying stories about dementia and ageing. While the media in India is now more receptive to these stories as part of their role in informing the public and stimulating debate, efforts are required to alert them of the importance of ageing and dementia, and to build their capacity to report, research and understand its local relevance. Health care professionals should have necessary skills to manage common health problems affecting older people. Medical training needs to reorient itself to meet the Healthcare needs of an aging society.

In the last 10 years, the evidence on dementia prevalence in India has expanded considerably. More than 42,000 older people have been studied in eight centres across India, and wide variations in estimates exist. Prevalence of dementia using survey diagnosis or clinical diagnosis of DSM IV or ICD 10 reported from Indian studies range from 0.6 % to 3.5% in rural areas and 0.9% to 4.8 % in urban areas. The difference in reported prevalence could be explained by lack of sensitive and specific local measures of assessment, methodological differences in the studies and a host of genetic, sociocultural and environmental factors.

Studies from developing countries have found increased mortality risk for older people with dementia. In two studies from Brazilian and Nigerian on over 6000 individuals aged 65 years and over, a 51.3% death rate for the dementia group compared to non dementia group was found. Persons with dementia from Nigeria died within five years of the diagnosis. The only study from India, conducted in Chennai, investigated predictors of mortality among older people living in the community. The study reported a higher risk of mortality (2.3 times) for older people who received a diagnosis of dementia at the baseline survey and risk of mortality was linearly associated with the severity of cognitive impairment.

Nurses are vital sources in educating the public on various health related issues. Hence the investigator is interested to assess the knowledge of elders regarding Dementia. Furthermore, the study of this kind will serve as guidelines for future elders to provide comprehensive care for Dementia.

Dementia does not discriminate on the grounds of gender, culture or intellect. Whilst risk factors increase with age, younger people can also be affected, because Lack of early diagnosis and support, Lack of awareness in general hospital wards of the special needs of patients with dementia, Lack of palliative care – either in hospital, hospice or own home, Lack of awareness of the help that can be given by friends, neighbors, shops or local services. etc.,

Keeping above fact in few researcher is keen to assess the knowledge of elders regarding dementia so that knowledge gap can be filled up by educating the elders, caregivers and public and increasing awareness about dementia and accept the individual who is suffering dementia as an important member of society.

STATEMENT OF THE PROBLEM

A quasi experimental study to assess the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in a selected village at Tirupur(Dt).

OBJECTIVES OF THE STUDY

1. To assess the pre test and post test level of knowledge regarding dementia among elderly in experimental group and control group.
2. To evaluate the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in experimental group.
3. To find the association between the post test level of knowledge on dementia and the selected demographic variables among elderly in experimental group

HYPOTHESES

H_1: There is a significant difference between the pre test and post test level of knowledge regarding dementia after STP among elderly in experimental group.

H_2: There is a significant difference in post test level of knowledge regarding dementia among elderly between experimental group and control group.

H_3: There is a significant association between the post test levels of knowledge on dementia among elderly and their demographic variables in experimental group.

OPERATIONAL DEFINITIONS

1. **Assess:** In this study assess refers to estimate or judge the level of knowledge regarding dementia among elderly by using structured questionnaire.

2. **Effectiveness:** In this study, effectiveness refers to the extent to which STP has brought about significance difference in the level of knowledge regarding dementia among elderly which was assessed using structured questionnaire.

3. **Structured teaching program:** It is a Systemic Structured lecture given by the investigator for 60 minutes with the help of showing pictures regarding dementia.

4. **Level of Knowledge:** In this study level of knowledge refers to the extent of correct response regarding dementia among elderly and assessed by structured questionnaire.

5. **Elderly:** In this study elderly refers to those individuals above 50 Years of age who are residing in selected village.

6. **Dementia:** It refers to a condition in which there is a gradual loss of brain function; it is a decline in cognitive/intellectual functioning The main symptoms are usually loss of memory, confusion, problems with speech and understanding, changes in personality and behavior and an increased reliance on others for the activities of daily living.

ASSUMPTIONS

1. Elderly may have little or inadequate knowledge regarding dementia.

2. Responses of dementia to the questionnaire will reveal their knowledge about dementia.

3. The elderly will extend their co-operation at the time of data collection and also to conduct structured teaching programme.

DELIMITATIONS

The study is delimited to;

- The elderly who are living in palayakottai at Tirupur (Dt)
- Sample selected by Non probability purposive sampling technique.
- Data collection period is only four weeks.

CONCEPTUAL FRAME WORK

Conceptual frame work is an organized phenomenon which deals with concepts that are assembled by virtue of their relevance to a common theme. The present study was aimed at assessing the effect of structured teaching program on dementia among elderly. The conceptual frame work for the present study was based up on the Nursing Process model (ANA 1991).

1. ASSESSMENT

Assessment is the deliberate and systematic collection of data to determine a client's current and past health status.

In this study assessment include-

- **Pre test knowledge**: Knowledge assessment include causes, risk factors, clinical features, management, prevention, prevention of reoccurrence, complication.
- **Selected factors of elders**: Age, gender, religion, marital status, educational status, occupation, number of children, type of family, family income, hobbies, previous sources of information regarding dementia.

2. PLANNING

Assessment of data helps in formulating nursing diagnosis, which forms the basis of planning nursing care. Through planning, the nurse determines what needs to be accomplished, in which priority the needs have to be met and how it should be done.

In this study planning includes preparation of structured teaching program for experimental group with the goal to improve the knowledge level and control group no activity.

3. IMPLEMENTATION

During this step individual nursing care is given to client according to the plan. Intervention are continually modified as needed or seemed necessary by an ongoing nursing assessment of the client response.

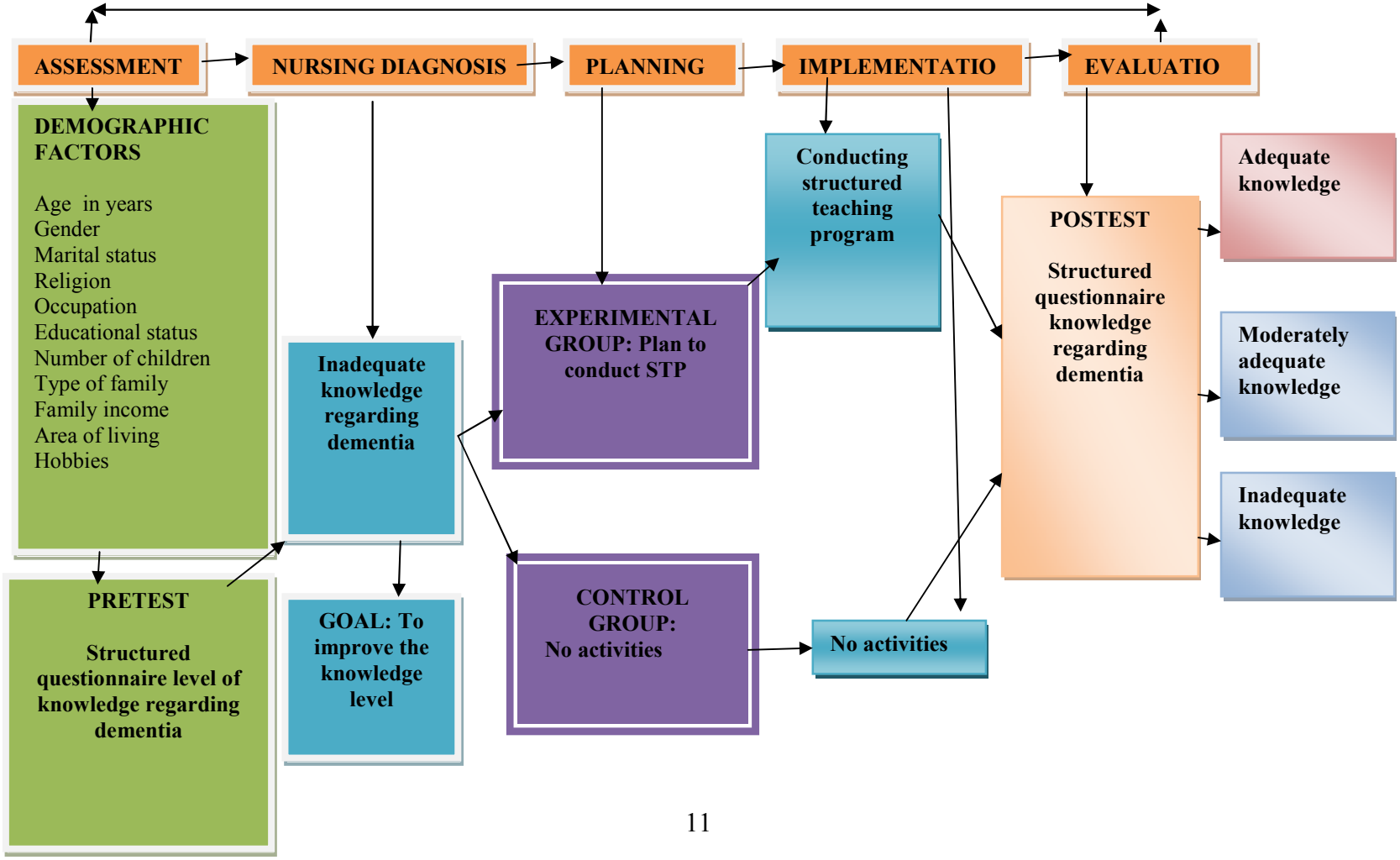
Screening a structured teaching program on dementia for experimental group and control group no activity.

4. EVALUATION

The nurse determines the client's progress towards meeting the behavioral outcomes and the success of the nursing intervention.

To evaluate the post test level of knowledge for experimental group and control group based on score key as adequate knowledge, moderate, inadequate.

FIGURE - 1


ASSESSMENT
NURSING DIAGNOSIS
PLANNING
IMPLEMENTATIO
EVALUATIO
DEMOGRAPHIC FACTORS
Age in years
Gender
Marital status
Religion
Occupation
Educational status
Number of children
Type of family
Family income
Area of living
Hobbies
PRETEST
Structured questionnaire level of knowledge regarding dementia
Inadequate knowledge regarding dementia
GOAL: To improve the knowledge level
EXPERIMENTAL GROUP: Plan to conduct STP
CONTROL GROUP: No activities
Conducting structured teaching program
No activities
POSTEST
Structured questionnaire knowledge regarding dementia
Adequate knowledge
Moderately adequate knowledge
Inadequate knowledge

CHAPTER-II

REVIEW OF LITERATURE

'As we grow older, we must discipline ourselves to continue expanding, broadening, learning, keeping our minds active and open'

-Clint *Eastwood*

A review of literature enables one to get an insight into the various aspects of the problems under the study. This involves the systematic, identification, location, and summary of written materials that contain information on a research problem.

This chapter deals with literature review on effect of structured teaching programme on dementia under the following headings.

1. Studies related to incidence and prevalence of dementia.
2. Studies related to knowledge and awareness of dementia.
3. Studies related to effectiveness of structured teaching programme.

1. STUDIES RELATED TO INCIDENCE AND PREVALENCE OF DEMENTIA.

Bhardwaj A (1) et.al (2014), conducted a study on the prevalence of dementia in Migrant, urban, rural, and tribal elderly population of Himalayan region in Northern India. Four settings identified for the purpose of this study included a migrant, urban, rural, and tribal. The study was conducted in two phases a screening phase and a clinical phase among 2,000 individuals above 60 years of age. To complete the required sample of 2,000 elderly individuals, 500 individuals were approached from each site. Nobody

refused to participate. The result of the study was a total of 32/2,000 (1.6%) elderly individuals were classified as demented. No case of dementia was reported from tribal population. A look at sex differential reveals that majority (21/32; 66%) of individuals identified as demented were females. As age advanced scores on cognitive screen decreased with elders above 80 years of age showing lowest scores. Out of 32, 18 (56%) of patients classified as demented were more than 80 years of age. The findings of this study are in agreement with previous studies which point towards differential distribution of dementia across populations.

Blom K' et al (2014), conducted a study on influence of vascular risk factors on cognitive decline in patients with Alzheimer's disease. This study aims to examine the association between VRFs and the rate of cognitive decline in patients with Alzheimer's disease (AD). The results showed that 174 patients (mean age 78.3 years), with a follow-up time up to 5.8 years (mean 1.1 year), in total 447 MMSE scores were obtained. The multivariable analyses showed an association between age as well as systolic blood pressure and a decline in annual rates of change in MMSE scores of -0.05 (95% confidence interval (CI): -0.09 to 0.00) and -0.01 (CI: -0.03 to 0.00), respectively. For all other VRFs, including sex, patients did not show a significant difference. The conclusion of this study did not find an association between preventable vascular risk factors and cognitive decline in patients with AD, except for systolic blood pressure. As the association between systolic blood pressure and decline in MMSE was small, clinical relevance may be limited.

Banerjee Tk et.al (2014), conducted a 7-Year Prospective Study Dementia and Cognitive Impairment in Patients with Parkinson's disease From India. This 7-year longitudinal study is a hospital-based prospective case (n = 250)-control (n =280) study. In all, 36.8% had PD with no cognitive impairment (PD-Normal), 27.2% of the patients with PD were affected by dementia (PDD), and 36% of the remaining patients with PD had mild cognitive impairment (PD-MCI) at baseline. After 7 years of evaluation, 32 new patients, 12 patients from the PD-MCI group and 9 patients from the PD-Normal

group, were diagnosed with dementia. The 7-year prevalence rate for dementia was estimated to be 49.28%. In the Indian population, an early onset of dementia is noted among patients with PD, with the age of onset being less than 55 years. Patients with early-onset PDD showed depression symptoms that differed significantly from the controls of the same age-group. There was a major difference in verbal fluency, word list recall, constructional praxis and recall, word list recognition, abridged Boston Naming Test, word list memory with repetition, and Mini-Mental State Examination between PD-MCI and PDD groups. Hallucinations before baseline (odds ratio [OR] = 4.427, 95% confidence interval [CI] = 2.122-9.373), akinetic/tremor dominancy (OR =0.380, 95%CI = 0.149-0.953), and asymmetrical disease onset (OR = 0.3285, 95%CI =0.1576-0.685) can be considered as risk factors for patients with dementia. Patients with early-onset PD might be more prone to complex depression and dementia.

Landefeld CS et al (2013), conducted a study was done to determine the incidence of different types of dementia in the very old, and to explore the relation with age and gender. A dementia-free cohort was followed for an average of three years in Stockholm, Sweden. At the end of the follow-up, the subjects were interviewed by nurses, clinically examined by physicians, and cognitively assessed by psychologists. Disease cohort members were studied using death certificates, hospital clinical records and discharge diagnoses. Results showed that during the follow-up, 148 subjects developed dementia. In the age-group 75 to 79, the incidence rates for dementia were 19.6 for women and 12.4 for men per 1,000 person-years.

Hanna M et.al (2013), conducted an exploratory study to assess the epidemiology of dementia among old age population among urban community, Calcutta. The sample size for the study was 350 old age population. The study results showed that over all prevalence of dementia is between 15-18% after 65yrs of age. And it doubles with every 5yrs increase in age.

Fortinsky RH et al (2013) conducted a multicentre cross-sectional, observational study was conducted to determine the prevalence of dementia in nursing homes in Spain among 852 residents to analyze the associated factors in an elderly population in the institutional setting they performed. Dementia was diagnosed to the DSM-IV-TER clinical criteria. The Hughes Clinical Dementia rating scale was used to measure global impairment or the global severity of dementia. The overall prevalence of dementia was 61.7% and that of Alzheimer's disease was 16.9%,vascular dementia was found in 7.3% female sex ,was independently associated with a greater frequency of dementia. The prevalence of dementia increased with age. The study concluded that two third of the elderly persons living in nursing home in Spain have dementia.

Etherton-Beer CD. (2013). Conducted an epidemiological study for dementia in an urban community-resident population in Mumbai, India, wherein the prevalence of all types of dementia was determined. From a potential pool of 30,000 subjects aged 40 years or more, 24,488 (male = 11,875; female = 12,613) persons completed self-report or interviewer-rated protocols based on the Sandoz Clinical Assessment Geriatric Scale, but 5,512 (18.37%) persons refused to participate. The prevalence rate for dementia in those aged 40 years and more was 0.43% and for persons aged 65 and above was 2.44%. Seventy-eight individuals had a CDR of [greater-than-or-equal] 1 yielding an overall prevalence rate of 0.32%, and a prevalence rate of 1.81% for those aged 65 years and older. The overall prevalence rate for Alzheimer's disease (AD) in the population was 0.25%, and 1.5% for those aged 65 years and above. The prevalence of AD and other dementias is less than that reported from developed countries but similar to results of other studies in India. Prevalence of the dementia syndrome increased with age. AD was the most common dementia and the prevalence was higher in women than in men.

Zhang L (4) et.al (2013), conducted a cross-sectional studies to assess the prevalence and predictors of mild cognitive impairment of dementia on community-based study among the elders. Mild cognitive impairment (MCI) is an intermediate stage between normal cognitive function and dementia among aging individuals. This study

was designed to estimate the prevalence of MCI and explore the possible risk factors including gender disparities among community-dwelling older individuals. A total of 815 individuals, 60 years and older were selected by stratified random cluster sampling. Cognitive function was measured using the mini-mental status examination (MMSE), the Chinese version of the Dementia Rating Scales (CDRS) was used to apply the diagnostic of non-dementia, and activities of daily living (ADL) and instrumental activities of daily living (IADL) systems were used to functional status. The association between socio demographic characteristics, lifestyle, history of chronic diseases and MCI were evaluated separately for men and women using the Pearson χ^2-test and binary logistic regression. Of the 815community-dwelling individuals, 145 were found to have MCI. Overall, the prevalence of MCI was 18.5%, with a prevalence of 19.6% in women (105/535), and 15.3% (40/261) in men. The results of the binary logistical regression analysis indicated that age and history of stroke were associated with MCI in men. For women, the risk factors were lower level of educational and lack of religious attendance.

Onishi K. et al (2010), conducted a study to assessed the challenge of estimating the prevalence of dementia in the elderly. The aim of the study was to examine the validity of the estimation of the prevalence of dementia in the elderly based on long-term care insurance (LTCI) data. Japanese LTCI data among frail elders over 65 years of age (193 men, 360 women) from a central area of Osaka prefecture in 2005 was analyzed using the dementia discrimination criteria of dementia autonomy level higher than level 2. Of those, no cases with a prior diagnosis of dementia were reexamined to ascertain dementia-equivalent status. The result of the study was 70 reexamined cases (25 men, 45 women), 6 men and 16 women scored as dementia-equivalent. In addition, 7 men and 7 women experienced severe squeal of cerebrovascular disease (CVD). Two men and 8 women showed symptoms equivalent to mild cognitive impairment (MCI). Ten men and 14 women showed no dementia/MCI. Based on the sum of subjects previously diagnosed with dementia and those with symptoms equivalent to dementia upon reexamination, the estimated prevalence of dementia in subjects over 65 years in the study region was 5%. The study concluded that a 50% capture rate of dementia based on the LTCI data (N = 553) from a review of previous research, the estimated prevalence of dementia was

increased to 10% after incorporating the results of this study. The prevalence of elderly dementia according to LTCI data should be estimated based on a determination of dementia-equivalence in terms of the level of care required dementia, equivalent to dementia (i.e., requiring daily care similar to that for dementia), and severe squeal of CVD. Furthermore, the capture rate should be carefully considered.

Lichtenberg PA et.al (2011) conducted a descriptive study to assess the incidence of dementia among old age people in selected rural population, Karnataka. The study sample size was 120 old age people. The study results showed that the incidence of dementia is estimated as 10% 0f old age having dementia over 65 years of age and 35% of old age having dementia over 85years of age.

Blom K' et al (2011), conducted a door-to-door survey was conducted to investigate the prevalence, psychosocial correlates and risk factors of various dementia disorders in an urban population in Kerala, southern India on 2005. They selected sample from the city of Kochi by using cluster sampling, to identify residents aged ≥65 years. Of 1934 people screened with a vernacular adaptation of the Mini-Mental State Examination, all those scoring at or below the cut-off of 23 were evaluated. The prevalence of dementia was 33.6 per 1000 (95% CI 27.3-40.7). Alzheimer's disease was the most common type (54%) followed by vascular dementia (39%), and 7% of cases were due to causes such as infection, tumour and trauma. According to this survey Dementia (AD) is an important health problem of the elderly population.

Mehta KM et al (2010) conducted a study was done at Rotterdam which country to estimate the prevalence of dementia and its subtypes in the general population and examine the relation of the disease to education. It was conducted as population based cross sectional study at Ommoord, a suburb of Rotterdam where 7528 participants aged 55-106 years took part. 474 cases of dementia were detected, giving an overall prevalence of 6.3%. Prevalence ranged from 0.4% at age 55-59 years to 43.2% at 95

years and over. Alzheimer's disease was the main sub diagnosis (339 cases) it was also the main cause of the pronounced increase in dementia with age. The relative proportion of vascular dementia (76 cases: 16%), Parkinson's disease dementia (30.6%) and other dementias (24.5%) decreased with age.

Grover A et al (2010), conducted a descriptive study regarding the awareness of putative risk factors for Alzheimer's disease among elderly Koreans. A total of 2767 randomly selected from the Asian Geriatric study were questioned on their knowledge of risk factors for Alzheimer's disease. The results showed that the most commonly stated risk factor was being older (59.6%), followed by head trauma (33.6%), and Cerebro Vascular Disease (30.4%). The study concluded that AD was more prevalent in older subjects and those with a lower level of education, and so public health education on the basic concepts of AD should be targeted at this population.

Palmer RM et al (2008), conducted a longitudinal Study of Aging was conducted at Baltimore to estimate age-specific incidence rates of AD. A sample size of 1236 participants (802 men, 434 women) in the BLSA with longitudinal follow –up were taken between January 1985 and May 1998. The average length of follow-up was 7.5 years, with participants evaluated every 2 years by physical, neurological, and neuropsychological examinations. The authors diagnosed 155 cases of dementia, of which 114 (74%) were AD. It was concluded that incidence rates for AD in the BLSA offer a unique opportunity to prospectively investigate the antecedents of AD.

2. STUDIES RELATED TO KNOWLEDGE AND AWARENESS OF DEMENTIA.

Rullier L et.al (2013) conducted a study was conducted on providing education about Alzheimer's disease. Improving carers' knowledge of Alzheimer's disease has been associated with benefits for carer well-being. Dementia knowledge was measured before

and after interventions designed to improve knowledge in a sample of 100 undergraduate students. Results showed that education improved Knowledge of Alzheimer's disease by 50% to 85%, as measured by increased scores on a dementia knowledge questionnaire. This study has important implications for public education about dementia and resource allocation for service providers.

Huang HL et.al (2012), conducted a cross sectional study was conducted to investigate public stigma (stereotype, prejudice, discrimination) relating to Alzheimer's disease among elders. The data was collected by interview from 500 people aged between 50-65yrs living within the community. The study results showed that the 41.6% of the participants expressed stereotype; 43.4% prejudice, and 35.5% discrimination. The study concluded that dimension of stigma were highly prevalent in relation to Alzheimer's disease and more interventions are needed to reduce the effect of stigma.

Phelan EA et.al (2012), conducted a study was conducted to examine the knowledge about Alzheimer's disease among 794 people by using knowledge questionnaire. The study results showed that the Knowledge about Alzheimer's disease was lower for dementia care givers, older adults, senior centre staff and undergraduate students. Across groups, respondents don't know about risk factors and prevention of Alzheimer's disease. The study concluded that the awareness program is necessary to the public about Alzheimer's disease.

Simonsick EMet.al (2012), conducted a population-based study was conducted among elderly Japanese-American men living on the island of Oahu, Hawaii. Data taken for this study was from the dementia prevalence survey. A total of 21% of family informants failed to recognize a problem with memory among subjects subsequently found to have dementia. Among subjects with very mild dementia, 52% of family informants failed to recognize a significant memory problem compared with 13% among more severely demented subjects. Of the subjects with dementia whose family

informants did recognize a memory problem, 53% failed to receive a medical evaluation for this problem. The study concluded that unrecognized dementia was common in our population, especially among mild cases. Cognitive screening programs for the elderly and public education policies designed to increase awareness of early signs of dementia are needed if interventions for individuals with potentially treatable dementias are to be implemented.

Rubin SM et.al (2011), conducted a descriptive survey was carried out to investigate knowledge and fear of developing Alzheimer's disease in a sample of healthy elders. The sample size was 127 young elders and 118 older elders. The data was collected by using knowledge questionnaire; Younger elders obtained a score of 54 % while older elders obtained 58% on knowledge test. Knowledge and fear scores were not significantly correlated with having a family member or knowing someone with Alzheimer's disease.

Acosta I et al (2010), conducted a descriptive study was conducted to assess the knowledge regarding of early identification of dementia among family members in selected families Maharashtra, sample size for the study was 100. The study results showed that 61.3% of the family members are having inadequate knowledge regarding early identification of dementia, and 6.5% of family members having adequate knowledge.

Yang SY et.al (2010), conducted a study was conducted to investigate awareness of dementia among elders attending dementia-prevention programs in community healthcare center, Department of Geriatrics. Regarding the knowledge about dementia, 17% of the participants knew about drug therapy, and 13% of them knew about legal guardianship. The results indicated a limited knowledge about facilities where demented people can be placed (home: 39%, hospital: 43%, nursing home: 62%, group-home: 25%). The study concluded that the education of dementia to older adults may contribute to early diagnosis of the community level, thereby may maximize the effect of therapeutic interventions.

Meillon C(2) et.al (2009), a study was conducted to assess the racial differences in knowledge and attitudes about Alzheimer's dementia among older adults .Data collected from 1176 older adults aged 45 years and over (48.6% White, 25.7%Black, and 25.8% Hispanic) obtained through telephone interview. The result showed that Compared with White and Black respondents, Hispanics were more likely to report feeling well-prepared for handling a diagnosis of Alzheimer's disease in a family member. The study concluded that misconceptions about Alzheimer's dementia remain among large segments of the population and continued efforts are needed to educate the public about this disease.

Sosa AL et al (2009), a descriptive study was conducted to assess the knowledge regarding self care aspects of patients with dementia among primary health care givers on government medical college Pune. Sample size for the study was 100. The study results showed that 42.3% of the primary care givers had adequate knowledge regarding self care while others have inadequate knowledge.

3. STUDIES RELATED TO EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME

Zerinet.al (2012), conducted a study with an aim to evaluate the effectiveness of structured teaching program on knowledge and practice regarding management of thrombolytic therapy among 40 staff nurses working in selected hospital, Bangalore revealed that mean post test knowledge score 69.19 was higher than mean pre test knowledge score 34.05 with the't' value of 26.05 and found to be significant at p 0.001. The author concluded that STP was effective method of providing information on knowledge and practice regarding management of thrombolytic therapy

Sunu Thomas (2012) done a study to assess the effectiveness of video assisted teaching programme on knowledge regarding care of tuberculosis among care givers of tuberculosis patients admitted in pravara rural hospital, Bangalore. Samples were

selected with non probability purposive sampling technique and 50 samples were selected. Results showed video assisted teaching practice found to be effective in improving the knowledge of care givers on care of the symptoms, compliance with the treatment, early recognition and prevention of complications.

Zahara Aziz (2011) has done a study on video teaching strategies to increase science subject knowledge to pupils in primary school at Malaysia. Samples were selected randomly 18 pupils in five years from one of the national school in bangsar. Findings of this study were video teaching strategy helped pupils to improve their understanding of basic concepts and knowledge in science. Students showed positive changes in attitude and interest.

Donkor (2010) done a comparative study on instructional effectiveness of print based and video based instructional materials for teaching and practical skills at a distance in U.S.A. Samples were selected randomly34 participants who used print based instructional materials and 35 participants who used video based instructional materials to learn practical skills. Data was collected with use of performance test and achievement test. The results of this study indicate practical skills were significantly higher among users of video based instructional materials students.

Boscardin WJ et al (2009) conducted a pre experimental research study of one group pre and post test was undertaken to evaluate the effectiveness of structured teaching programme module on care of dementia patients developed for B.Sc nursing students in Mangalore. Purposive sampling technique was used to select the samples; data was collected through a structured closed ended questionnaire. Pre test result revealed that 96% of students had average knowledge and 4% of students had poor knowledge on care of dementia patients. Post test result revealed that 72% of students have good knowledge and 28% very good knowledge .Findings of the study revealed that there was highly significant increase in the knowledge of nursing students regarding the care of dementia patients.

CHAPTER-III

METHODOLOGY

According to **Polit and Beck (2012)** research methods are the techniques used by researchers to structure a study and to gather and analyze information relevant to research question.

Research methodology involves the systematic procedure by which investigator starts from the initial identification of the problem to its final conclusion. Methodology is a significant part of any study which enables the researcher to project the research undertaken.

This chapter deals with research design, setting, population, sample and sample size, sampling technique ,sample selection criteria, description of the tool, scoring, validity of the tool, reliability of the tool, pilot study, data collection procedure, plan of data analysis and ethical consideration.

RESEARCH APPROACH

According to **Suresh K. Sharma (2011)** the research approach involves the description of the plan to investigate the phenomenon under study in a quantitative, qualitative or a combination of the two methods. Furthermore, it helps to decide whether the presence or absence as well as manipulation and control over variables. Also, it helps to identify the presence or absence of and comparison between groups.

The present study is an evaluative research approach. Evaluative research study is an applied form of research design in which the judgment is made on how well a specific practice or program is working. It is used to determine the effectiveness of processes or equipment used in a particular setting.

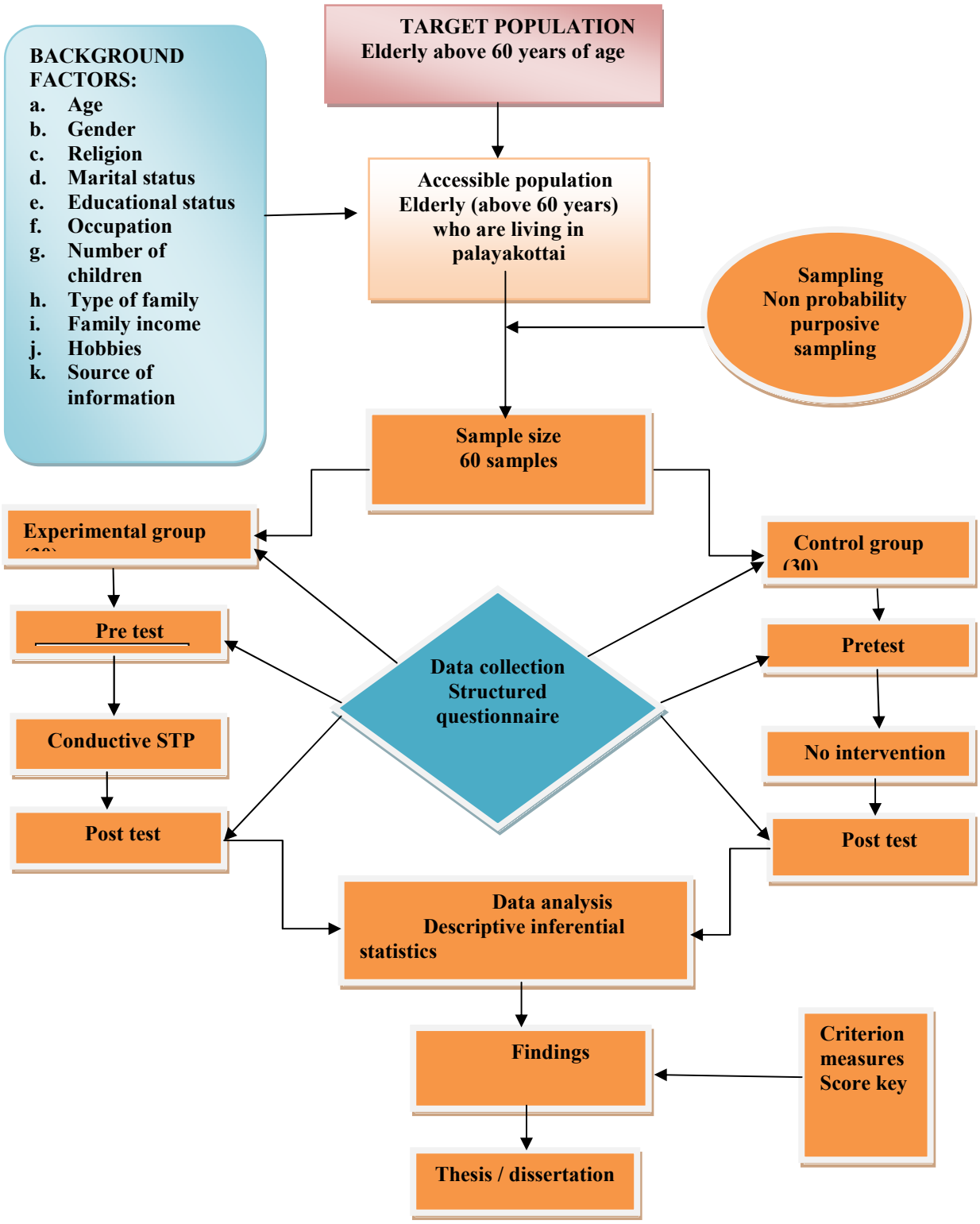
The definitive aim of the present study is to evaluate the effectiveness of structured teaching programme regarding dementia among elderly.

RESEARCH DESIGN

According to **Polit and Beck (2012)** the research design is the overall plan for obtaining answers to the questions being studied and for handling some of the difficulties encountered during the research process.

The research design selected for the present study was a quasi experimental pre and post test design to evaluate the effectiveness of structured teaching program on level of knowledge regarding dementia among elderly. There were two groups, experimental and control group. The experimental group included those elderly who differed from control group only with regard to attending the structured teaching program. Pre test were measured in both experimental and control group. Structured teaching program was attended by experimental group elderly. Post test were measured for both groups.

FIGURE -2


TARGET POPULATION
Elderly above 60 years of age
BACKGROUND FACTORS:
a. Age
b. Gender
c. Religion
d. Marital status
e. Educational status
f. Occupation
g. Number of children
h. Type of family
i. Family income
j. Hobbies
k. Source of information
Accessible population
Elderly (above 60 years) who are living in palayakottai
Sampling
Non probability purposive sampling
Sample size
60 samples
Experimental group
Control group (30)
Pre test
Pretest
Data collection
Structured questionnaire
Conductive STP
No intervention
Post test
Post test
Data analysis
Descriptive inferential statistics
Findings
Criterion measures
Score key
Thesis / dissertation

NOTATION:

GROUP	PRE TEST	INTERVENTION	POST TEST
Experimental group	O_1	X	O_2
Control group	O_1	-	O_2

A symbol used in study is;

O_1 : Pre test to assess the level of knowledge regarding dementia among elderly in control group and experimental group.

X : Structured teaching program to experimental group.

O_2 : Post test to assess the level of knowledge regarding dementia among elderly in control group, experimental group.

VARIABLES

According to **Suresh K Sharma (2011)** variables are qualities, quantities, properties, or characteristics of people, things, or situations that change or vary.

The categories of variables discussed in the study were;

INDEPENDENT VARIABLE

Variable causing change is referred to independent variable. It is the intervention or treatment that the investigator performs to see the resulting change in the dependent variable.

Independent variable: Structured teaching program on dementia. It is a Systemic Structured lecture given by the investigator for 60 minutes with the help of showing pictures regarding dementia.

DEPENDENT VARIABLE

It is the focus of the study and reflects the empirical aspects of the concepts being studied.

Dependent variable: level of Knowledge of elderly regarding dementia.

EXTRANEOUS VARIABLE:

Age, gender, religion, marital status, educational status, occupation, number of children, type of family, family income, area of living hobbies, previous sources of information regarding dementia.

SETTING

The selection of setting was done on the basis of feasibility of conducting the study, availability of subjects and cooperation of the authorities. The data was collected in palayakottai at tirupur (dt)

POPULATION

Population consists of the entire set of individual events, places or objects that possess the specific characteristics or attributes being studied. It also refers to the aggregate or totality of all the subjects.

Target population is the aggregate of cases about whom the investigator would like to make generalization. In this study, elderly were the target population.

Accessible population is the aggregate of cases that confirm to the designed criteria and which is accessible to the investigator as a part of subject for conducting the study. The accessible population selected for this study was elderly who are living in palayakottai at tirupur (dt).

SAMPLE AND SAMPLE SIZE

The sample size was determined arbitrarily by the type of the study, variables being studied, feasibility of time, money, and material. In this study, the sample size was arbitrarily decided to be 60elderly in which 30 were in experimental group and 30 were in control group

SAMPLING TECHNIQUE

Sampling is the process of selecting a portion of the population to represent the entire population. In this study the investigator selected the sample by Non probability purposive sampling technique.

SAMPLE SELECTION CRITERIA

The study samples were selected using the following criteria

Inclusion criteria: elderly

- Who are available at the time of data collection

- Who are willing to participate
- Who are able to cooperate throughout the period of the data collection
- Who knows to read and write Tamil.

Exclusion criteria

1. Who are sick at the time of data collection.
2. Who have already undergone teaching program regarding dementia.

DEVELOPMENT OF TOOL

The investigator developed a structured knowledge questionnaire as tool for present study after exploring all sources of information like extensive library search, internet sources and consultation with experts. The experts were requested to check for the relevance, sequence and clarity of the tool. Modification was done according to expert's opinion and the final tool was developed. The tool was translated into Tamil and again it was retranslated into English, thereby, the language validity was ascertained. In the present study the reliability of the structured questionnaire was established by test – retest method, among 10 elderly. Reliability coefficient was r =0.92 and the tools were found to be reliable for the study.

DESCRIPTION OF THE TOOL

The tool used for the research study was structured knowledge questionnaire regarding dementia, tool consists of two parts.

PART I: Back ground data

PART II: structured questionnaire

PART I:

Background data of elderly, consists of 11questions seeking information on the background data of students. The items included Age, gender, religion, marital status, educational status, and occupation, number of children, type of family, family income, hobbies, and previous sources of information regarding dementia.

PART 2:

Structured questionnaire for assessing the level of knowledge regarding dementia among elderly.

It contains 25 items, each carries 1 mark. The highest possible score is 25.The lowest score for each question is 0.

SCORING PROCEDURE:

- Maximum score-25
- Minimum score –0

SCORE	PERCENTAGE (%)	LEVEL OF KNOWLEDGE
0 -13	0 -50%	In adequate knowledge
13 -20	50 - 75 %	Moderately adequate knowledge
21 -25	> 75%	Adequate knowledge

VALIDITY OF THE TOOL

Six experts including two psychiatrists, one visual engineer, and three nursing experts validated the tool for its content. The experts were requested to check for the relevance, sequence and clarity of the tool. Modification was done according to expert's opinion and the final tool was developed. The tool was translated into Tamil and again it was retranslated into English, thereby, the language validity was ascertained.

RELIABILITY OF THE TOOL

In the present study the reliability of the structured questionnaire for experimental group and control group was established by test –retest method, among 10 elderly. Reliability coefficient was r =0.92 and the tool were found to be reliable for the study.

PILOT STUDY

The pilot study was conducted in archuna nagar at nathakadaiyur .It was conducted only after the tool presentation and approval of college of nursing faculty and dissertation committee. Validity and reliability of the instrument were tested during this time. The pilot study was done to obtain information to improve the project or assess its feasibility. The pilot study was conducted among 10 elderly, 5 elderly in control group and 5 elderly in experimental group. Who fulfilled the sample criteria for sample selection and those elderly were excluded from the main study. Pre test, structured teaching programme, and post test was done and feasibility of the study was established. It also helped to select suitable statistical method.

STRUCTURED TEACHING PROGRAMME

Recorded the content related to dementia. The content of the CD was validated by the experts and by visual communication engineer for the clarity and accuracy of the visual.

DATA COLLECTION METHOD

The present study was conducted in palayakottai at tirupur (dt). The data were collected for 4 weeks from 1st of April 2014 to31st April 2013.Permission was sought and obtained from authorities of the village. The study samples were selected by Non probability purposive sampling technique based on sample selection criteria. The study purpose and method were explained to the selected sample. Informed consent was obtained from the study participant's for participating in the study. The sample size was 60elderly people.

Pre test was conducted for 30 elderly in experimental, 30 elderly in control group. Background data and level of knowledge were collected by using structured knowledge questionnaire (multiple choice questions) to assess the level of knowledge regarding dementia among elderly. After pretest elderly in the experimental group attended the structured teaching programme .Post test score was assessed with same questionnaire 10 days after the structured teaching programme for both control groups, experimental group.

PLAN FOR DATA ANALYSIS

The data collected from subject were edited, compiled, and analyzed by using SPSS version 13. The probability level of 0.05 was used as the level of significance. The data were analyzed as follows;

1. Back ground Data obtained from the sample organized and summarized with the help of descriptive statistics like frequency, mean, percentage distribution, standard deviation.

2. Comparing the pre test and post test knowledge scores of experimental group elderly by using paired t' test.

3. Data on identifying the association between the pre test knowledge with selected socio-demographic variables of experimental group were analyzed using descriptive and chi-square test.

4. Data on effectiveness of structured teaching programme on dementia among control group and experimental group with the use of unpaired' test.

ETHICAL CONSIDERATION

For the present study, the investigator took into consideration the ethical values. The study was accepted by the research and ethical committee. Prior permission was obtained in palayakottai at tirupur (dt). Explanation regarding the purpose of the study was done and informed consent obtained from the study participant's for participating in the study. The study participants had the right to discontinue from the study at any time. No physical harm was done.

CHAPTER-IV

ANALYSIS AND INTERPRETATION

The analysis and interpretation of data of this study were based on the data collected by structure questionnaire method. The results were computed using descriptive and inferential statistics. The data were entered into excel sheet and analyzed using SPSS 13 version. The probability value of less than 0.05 was considered to be significant.

The objectives of the study were,

4. To assess the pre test and post test level of knowledge regarding dementia among elderly in experimental group and control group.
5. To evaluate the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in experimental group.
6. To associate the post test level of knowledge regarding dementia and the selected demographic variables among elderly in experimental group.

The data collected were edited, tabulated, analyzed, and interpreted, a findings obtained were presented in the form of tables, and diagrams under the following sections:

5. Back ground Data obtained from the sample organized and summarized with the help of descriptive statistics like frequency, mean, percentage distribution, standard deviation.
6. Comparing the pre test and post test knowledge scores of experimental group elderly by using paired t' test.

7. Data on identifying the association between the pre test knowledge with selected socio-demographic variables of experimental group were analyzed using descriptive and chi-square test.

8. Data on effectiveness of structured teaching programme on dementia among control group and experimental group with the use of unpaired't' test.

SECTION I: DATA ON BACKGROUND FACTORS OF ELDERLY IN EXPERIMENTAL GROUP AND CONTROL GROUP

TABLE – 1

FREQUENCY, PERCENTAGE OF ELDERLY ACCORDING TO BACKGROUND FACTORS IN EXPERIMENTAL AND CONTROL GROUP

N=60

S. NO	DEMOGRAPHIC VARIABLES	EXPERIMENTAL GROUP		CONTROL GROUP	
		F	%	F	%
1.	Age in years				
	a. 60 – 63years	12	40	15	50.0
	b. 64- 66 years	12	40	10	33.3
	c. Above 66 years	06	20	05	16.7
2.	Gender				
	d. Male	20	66.7	18	60.0
	e. Female	10	33.3	12	40.0
	f. Transgender	0	00.0	0	00.0
3.	Religion				
	a. Hindu	11	36.7	12	40.0
	b. Muslims	0	00.0	0	00.0
	c. Christian	19	63.3	18	60.0
	d. Others	0	00.0	0	00.0
4	Marital status				
	a. Single	0	00.0	0	00.0
	b. Married	18	60.0	22	73.3
	c. Widower	10	33.3	06	20.0
	d. Divorced	02	06.7	02	06.7

5	Educational status				
	a. Illiterate	23	76.7	19	63.3
	b. Primary education	03	10.0	06	20.0
	c. High school Education	0	00.0	0	00.0
	d. Degree and above	04	13.3	05	16.7
6	Occupation				
	a. Government employee	00	00.0	00	00.0
	b. Business man	03	10.0	02	06.7
	c. Private employee	18	60.0	15	50.0
	d. Cooley	05	16.7	06	20.0
	e. Retired/unemployed	04	13.3	07	23.3
7	Number of children				
	a. No children	00	00.0	03	10.0
	b. One child	11	36.7	09	30.0
	c. Two children	17	56.6	14	46.7
	d. More than 2 children	02	06.7	04	13.3
8	Type of family				
	a. Nuclear family	19	63.3	17	56.6
	b. Joint family	5	16.7	8	26.6
	c. Extended family	6	20.0	5	16.8
9	Family Income				
	a. < Rs-5000/-	6	20.0	4	13.3
	b. Rs.5001- 10000	15	50.0	7	23.4
	c. Above Rs 10000	9	30.0	19	63.3
10	Hobbies				
	a. Reading books and news paper	4	13.3	5	16.7
	b. Watching TV	20	66.7	22	73.3
	c. Chatting with friends	6	20.0	3	10.0
	d. None	0	00.0	0	00.0

11	Previous sources of information regarding Dementia				
	a. Yes	3	10.0	4	13.3
	b. No	27	90.0	26	86.7
	if yes				
	A. Friends	02	6.66	02	6.66
	B. Newspaper	01	3.33	02	6.66
	C. Mass media	00	0.00	00	0.00

Table No 1: Shows the frequency, percentage of elderly according to background factors in experimental and control group.

Regarding age in years in experimental group majority 12(40%) were in 60-63 years and 64 -66 years respectively and the least 6(20%) were above 66 years. Among control group majority 15(50%) were in 60-63 years of age, 10(33.3%) were 64 – 66 years, and the least 5(16.7%) were above 66 years of age.

Regarding gender in experimental group majority 20(66.7%) were males and the least 10(33.3%) were female, and among control group majority 18(60.4%) were males and the least 12(40%) were females.

Regarding religion in experimental group majority 19(63.3%) were Christians and the least 11(36.7%) were Hindus, among control group majority 18(60%) were found to be Christians and the least 12(40%) were in Hindu religion.

Regarding marital status in experimental group majority 18(60%) were married, 10(33.3%) were widowers and the least 2(06.7%) were divorced. Among control group majority 22(73.3%) were married, 6(20%) were widowers, and the least 2(06.7%) were divorced.

Regarding educational status in experimental group majority 23(76.7%) were illiterates, 4(13.3%) had high school education and the least 3(10%) had primary education. Among control group majority 19(63.3%) were illiterates, 6(20.0%) had primary education, and the least 5(16.7%) had high school education.

Regarding occupation in experimental group majority 18(60%) were working as private employees, 5 (16.7%) were working as coolie, 4 (13`3%) were retired/ unemployed, and the least 3(10%) were business men. Among control group majority 15(50%) were working as private employees, 7(23.3%) were retired/ unemployed, 6(20.0%) were working as coolie and the least 2(06.7%) were business men.

Regarding number of children in experimental group majority 17(56.6%) were having two children, 11(36.7%) were having one children, and the least 2(06.7%) were having more than two children. Among control group majority 14(46.7%) were having two children, 9(30.0%) had one children, 4(13.3%) had more than two children, and the least 3(10%) had no children.

Regarding type of family in experimental group majority 19(63.3%) were living as nuclear family, 6(20.0%) were living in extended family, and the least 5(16.7%) were living as joint family. Among control group majority 17(56.6%) were living as nuclear family, 8(26.6%) were in joint family, and the least 5(16.8%) were living as extended family.

Regarding family income in experimental group majority 15(50%) of their income was between 5001 to 10000, 9(30.0%) of their income was above 10000 and the least 6(20%) had income of less than Rs.5000. Among control group majority 19(63.3%) had the income of above 10000, 7(23.4%) were earning between 5001 - 10000 and the least 4(13.3%) had the income of less than 5000.

Regarding hobbies in experimental group majority 20(66.7%) had the hobby of watching TV, 6(20.0%) had the hobby of chatting with friends and the least 4(13.3%) had the hobby of reading books and news paper. Among control group majority 22(73.3%) had the hobby of watching TV, 5(16.7%) had the hobby of reading books and news paper, 3(10%) had the hobby of chatting with friends.

Regarding previous sources of information regarding dementia in experimental group majority 27(90%) did not have the previous sources of information regarding dementia and the least 3(10%) had the previous sources of information regarding dementia, among control group majority 26(86.7%) did not have the previous sources of information regarding dementia and the least 4(13.3%) had the previous sources of information regarding dementia.

It was inferred that in experimental group majority 12(40%) were from 60-63 years and 64 -66 years respectively, 20(66.7%) were males, 19(63.3%) elders were Christians, 18(60%) were married, 23(76.7%) were illiterates, and 18(60%) were working as a private employee, 17(56.6%) had two children, 19(63.3%) were living in a nuclear family, 15(50%) of their family monthly income was above Rs.5000, 20(66.7%), elders had the hobby of watching TV, 27(90%) elders did not have the previous sources of information regarding dementia.

It was inferred that in control group majority 50(50%) were from 60-63 years respectively, 18(60.4%) were males,18(60%) elders were Christians, 22(73.3%) were married, 19(63.3%) were illiterates, and 15(50%) were working as private employees, 14(46.7%) had two children, 17(56.6%) were living in a nuclear family, 15(50%)of their family monthly income was above 5000, 19(63.3%) elders had the hobby of watching TV, 26(86.7%) most of elders did not have the previous sources of information regarding dementia.

SECTION II: DATA ON PRE TEST, POST TEST LEVEL OF KNOWLEDGE REGARDING DEMENTIA AMONG ELDERLY IN EXPERIMENTAL GROUP

TABLE: 2

MEAN, RANGE, STANDARD DEVIATION, MEAN PERCENTAGE, MEAN DIFFERENCE, 'T' VALUE IN PRE TEST AND POST TEST LEVEL OF KNOWLEDGE SCORE OF CONTROL GROUP AND EXPERIMENTALGROUP.

Group	Mean		SD		Mean %		Range	Mean difference	't' value
	Pre test	Post test	Pre test	Post test	Pre test	Post test			
Control group	10.45	12.5	7.76	3.56	24.67	35.71	14	45.86	16.45 P<0.05 S
Experimental group	24.47	36.33	8.96	2.96	45	81.57	17.30		

Table 3: Shows post test knowledge score mean, S.D, mean percentage, mean difference, 't'value of control group and experimental group.

Pre test in experimental group the obtained over all mean score was 24.47, standard deviation was 8.96, mean percentage was 45 and in control group the obtained over all mean score was 10.4, standard deviation was 7.76,mean percentage was 35.71.

Post test in experimental group the obtained over all mean score was 36.33, standard deviation was 2.96, mean percentage was 81.57 and in control group the obtained over all mean score was 12.5, standard deviation was 3.56, mean percentage was 35.71.

The obtained posttest mean score in experimental group score was higher than the control group score.

SECTION III: DATA ON EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME REGARDING DEMENTIA AMONG ELDERLY IN CONTROL GROUP AND EXPERIMENTAL GROUP

TABLE:3

MEAN, RANGE, STANDARD DEVIATION (SD), MEAN PERCENTAGE, MEAN DIFFERENCE, ' T ' VALUE IN PRE TEST AND POST TEST LEVEL OF KNOWLEDGE REGARDING DEMENTIA AMONG ELDERLY IN EXPERIMENTAL GROUP.

Level of knowledge	Mean	SD	Mean %	Range	Mean difference	't' value
Pre test	24.47	8.96	45	10-23	36.57	16.43 P<0.05 S
Post test	36.33	2.96	81.57	17-30		

Table-3: Shows mean, range, standard deviation (SD), mean percentage, mean difference, ' t ' value of pre test and post test level of knowledge regarding dementia among elderly in experimental group.

The obtained overall pre test mean score was 24.47, standard deviations (SD) was8.96; and mean percentage was 45 and in the Post test mean score was 36.33, standard deviation was 2.96, and the mean percentage was 81.57. The mean difference was 36.57. The obtained't' value was 16.43 which was significant at $p<0.05$.

It was inferred that post test knowledge score was increased after the structured teaching programme in experimental group, it was found to be effective.

SECTION IV: DATA ON ASSOCIATION BETWEEN POST TEST KNOWLEDGE WITH SELECTED BACKGROUND FACTORS AMONG ELDERLY IN EXPERIMENTAL GROUP

TABLE-4

SHOWS ASSOCIATION OF SELECTED BACKGROUND FACTORS WITH POST TEST KNOWLEDGE SCORE IN EXPERIMENTAL GROUP

Demographic Variable	LEVEL OF KNOWLEDGE				
	Inadequate	Moderately adequate	Adequate	x^2 Value	Sig
Age in years					
a. 60 – 63years	0	4	8	$x^{2=5.045}$	(NS)
b. 64- 66 years	1	3	8		
c. Above 66 years	1	2	3		
Gender					
a. Male	2	8	10	$x^{2=18.85}$	(NS)
b. Female	1	5	4		
c. Transgender	0	0	0		
Religion					
a. Hindu	2	5	4		
b. Muslims	0	0	0	$x^{2=3.128}$	(NS)
c. Christian	3	7	9		
d. others	0	0	0		
Marital status					
a. Single	0	0	0		
b. Married	2	5	11	$x^{2=8.249}$	(NS)
c. Widower	1	4	5		
d. Divorced	0	1	1		

Educational status a. Illiterate b. Primary education c. High school education d. Degree and above	4 0 0 0	5 1 0 0	14 2 0 2	$x^{2=5.028}$	(NS)
Occupation a. Government employee b. Business man c. Private employee d. Cooley e. Retired/unemployed	0 0 1 1 1	0 0 9 2 2	0 3 8 2 1	$x^{2=1.184}$	(NS)
Number of children a. No children b. One child c. Two children d. More than 2 children	0 1 2 1	0 5 4 1	0 5 11 0	$x^{2=3.173}$	(NS)
Type of family a. Nuclear family b. Joint family c. Extended family	2 0 1	4 2 2	13 3 3	$x^{2=3.84}$	(NS)
Family Income a. < Rs-5000/- b. Rs.5001- 10000 c. Above Rs 10000	2 2 1	2 3 3	2 10 5	$x^{2=5.99}$	(NS)
Hobbies a. Reading books and news paper b. Watching TV c. Chatting with friends d. Non	0 2 0 0	2 5 1 0	2 13 5 0	$x^{2=2.13}$	(NS)

A Previous sources of information regarding Dementia	0	1	2		
a. Yes	2	5	20		
b. No					
If Yes				$x^{2=1.68}$	(NS)
a. Friends	0	1	1		
b. Newspaper	0	0	1		
c. Mass media	0	0	0		
d. All	0	0	0		

It was inferred that there was no significant association between the post test level of knowledge and selected background factors such as age, gender, religion, marital status, educational status, occupation, number of children, type of family, family income, hobbies and previous source of information among elderly in experimental group.

It was inferred that the structured teaching programme was independently effective in improving the level of knowledge regarding dementia among elderly

CHAPTER –V

SUMMARY, FINDINGS, DISCUSSION, IMPLICATIONS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

This chapter deals with summary, findings, discussion, implications, limitations, recommendations and conclusion. The essence of any research project is based on study findings, limitations; interpretation of the research results and recommendations to incorporate the study implications. It also gives meaning to the results obtained in the study.

SUMMARY

The prime aim of the study was to assess the knowledge on dementia before and after structured teaching programme among elderly.

The objectives of the study were,

- To assess the pre test and post test level of knowledge regarding dementia among elderly in experimental group and control group.
- To evaluate the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in experimental group.
- To find the association between the post test level of knowledge on dementia and the selected demographic variables among elderly in experimental group.

The study attempted to examine the following research hypothesis.

HYPOTHESES

H_1: There is a significant difference between the pre test and post test level of knowledge regarding dementia after STP among elderly in experimental group.

H_2: There is a significant difference in post test level of knowledge regarding dementia among elderly between experimental group and control group.

H_3: There is a significant association between the post test levels of knowledge on dementia among elderly and their demographic variables in experimental group.

Extensive Literature review was done for the present study, and the reviews are presented in the following headings, Studies related to incidence, prevalence of dementia, Studies related to knowledge and awareness of dementia, Studies related to effectiveness of structured teaching.

The conceptual framework adopted for the present study was based on the Nursing process model (ANA 1991).This model helped the investigator to assess the knowledge on dementia before and after conducting structured teaching programme**.**

The research design selected for the present study was a quasi experimental two group pretest and posttest design to evaluate the effectiveness of structured assisted teaching programme on dementia. The independent variable was structured teaching programme and dependent variables were level of knowledge regarding dementia among elderly.

The investigator developed a structured questionnaire as tool for the present study. The content validity of the tool was established by 6 experts. The reliability of the tool was ascertained by test retest method Reliability coefficient was r =0.92 and the tool was found to be reliable for the study. Pilot study was conducted in in archuna nagar at nathakadaiyur among 10 elderly, who fulfilled the sample selection criteria. The study was found to be feasible.

The main study was conducted in in palayakottai at tirupur (dt). Prior permission from the authorities was sought and obtained. Non probability purposive sampling technique was used to select the samples and informed consent was obtained. Pre test was done to assess the knowledge on dementia. Post test was done on 10^{th} day of class for control group and experimental group. The data gathered were analyzed and interpreted using SPSS package (version 13) A probability of $P < 0.05$ level of significance was considered significant.

FINDINGS

The major findings of the study were classified under following headings,

Finding1: Data on background factors of elderly in experimental group, control group.

In experimental group majority 12(40%) were from 60-63 years and 64 -66 years respectively, 20(66.7%) were in males, 19(63.3%) elders were Christians, 18(60%) were married, 23(76.7%) were illiterates, and 18(60%) were working as private employees, 17(56.6%) had two children, 19(63.3%) were living as a nuclear family, 15(50%) of their family monthly income was above 5000, 20(66.7%), elders hobbies was watching TV, 27(90%) elders did not have the previous sources of information regarding dementia.

In control group majority 50(50%) were from 60-63 years respectively, 18(60.4%) were in males,18(60%) elders were Christians, 22(73.3%) were married, 19(63.3%) were illiterates, and 15(50%) were working as private employees, 14(46.7%) had two children, 17(56.6%) were living as a nuclear family, 15(50%)of their family monthly income is above 5000, 19(63.3%) elders hobbies was watching TV, 26(86.7%) most of elders did not have the previous sources of information regarding dementia.

Therefore both groups were comparable in relation to selected background factors

Finding 2: Data on pre test, post test level of knowledge regarding dementia among elderly in experimental group and control group

In the pretest, in experimental group the obtained over all mean score was 24.47, standard deviation was8.96 and mean percentage was 45.86 and rang was 10.23

The obtained overall post test mean 36.33, standard deviation 2.96, and the mean percentage 81.57, range 17-30. Pre test mean 24.47, standard deviations (SD) 8.96; and24.47mean percentage mean difference36.57, the obtained‘ t’ value was16.43($p<0.05$) which was significant ay $p<0.05$

It was inferred that post test knowledge score in experimental group significantly high compare to post test knowledge score in control group. So the structured teaching programme was effective among experimental group of elderly

Finding 3 : Data on effectiveness of structured teaching programme regarding dementia among elderly in control group and experimental group and control group

In the pretest, in experimental group the obtained over all mean score was 24.47, standed deviation was8.96 and mean percentage was 45.86 and rang was 10.23

The obtained overall post test mean 36.33, standard deviation 2.96, and the mean percentage 81.57, range 17-30. Pre test mean 24.47, standard deviations (SD) 8.96; and24.47mean percentage mean difference36.57, the obtained‘t’ value was 16.43($p<0.05$) which was significant ay $p<0.05$

In control group post test knowledge score is low, mean 12.5, standard deviation 3.56, mean percentage 35.71, and the mean difference was 45.86, range 14, mean difference 45.86, ‘t’ value $t=16.45$ ($p<0.05$) was significant.

Finding 4: Data on association between post test knowledge score with selected background factors among elderly in experimental group.

There was no significant association between the level of knowledge and selected demographic factors among elderly in experimental group. Structured teaching programme was independently effective in improving the knowledge. regerding dementia among elderly

DISCUSSION

The results of the study were discussed according to the objectives of the study.

Objectives 1: To assess the pretest and post test level of knowledge regarding dementia among elderly in experimental group and control group.

The obtained overall post test mean 36.33, standard deviation 2.96, and the mean percentage 81.57, range 17-30. Pre test mean 24.47, standard deviations (SD) 8.96; and24.47mean percentage mean difference36.57, ‘ t’ value 16.43($p<0.05$) was significant.

It was inferred that post test knowledge score was increased after the structured teaching programme in experimental group.

Boscardin WJ et al (2009) conducted a pre experimental research study of one group pre and post test was undertaken to evaluate the effectiveness of structured teaching programme module on care of dementia patients developed for B.Sc nursing students in Mangalore. Purposive sampling technique was used to select the samples; data was collected through a structured closed ended questionnaire. Pre test result revealed that 96% of students had average knowledge and 4% of students had poor

knowledge on care of dementia patients. Post test result revealed that 72% of students have good knowledge and 28% very good knowledge .Findings of the study revealed that there was highly significant increase in the knowledge of nursing students regarding the care of dementia patients.

Objectives 2: To evaluate the effectiveness of structured teaching programme on the level of knowledge regarding dementia among elderly in experimental group.

The obtained over all experimental group post test knowledge score is high, mean 36.33; standard deviation 2.96, mean percentage was 81.57, range 17-30. In control group post test knowledge score is low, mean 12.5, standard deviation 3.56, mean percentage 35.71, and the mean difference was 45.86, range 14, mean difference 45.86, 't' value $t=16.45$ ($p<0.05$) was significant.

It was inferred that post test knowledge score in experimental group significantly high compare to post test knowledge score in control group. So the structured teaching programme was effective among experimental group of elderly.

Soteriades ES et al (2013) conducted a study was on a home environmental intervention effect on efficacy and upset in caregivers and on daily function of persons with dementia. A randomized, controlled trial approach was used. Families ($N = 171$) of dementia patients were randomized to intervention. Results showed intervention caregivers reported fewer declines in patients' Instrumental Activities of Daily Living (IADL) ($p = .030$) and less decline in self-care and fewer behaviour problems. Also, intervention spouses reported reduced upset ($p = .049$), women reported enhanced self-efficacy in managing behaviours ($p = .038$), and women ($p = .049$) and minorities ($p = .037$) reported enhanced self-efficacy in managing functional dependency. Researcher concluded that the environmental program appears to have a modest effect on dementia patients' IADL dependence. Also, among certain subgroups of caregivers the program improves self-efficacy and reduces upset in specific areas of care giving.

Objective: 3 To find the association between the post test level of knowledge on dementia and the selected demographic variables among elderly in experimental group.

It was inferred that there was no significant association between the post test level of knowledge and selected background factors such as age, gender, religion, marital status, educational status, occupation, number of children, type of family, family income, hobbies and previous source of information among elderly in experimental group.

IMPLICATION

The findings of the study have the following implications in nursing.

Implications for nursing practice

- Structured teaching programme helps to improve the clinical staff's knowledge level on dementia.
- Structured teaching method can be used as a one method of teaching in clinical nursing.
- Structured teaching method can be used in various old age home and community, psychiatric ward to give health education to the elders and care givers of the elders.
- Structured teaching method can be used in illiterate elders also. It helps to easy understanding the topics; it can use in mass group and community.

Implication for nursing education:

- ❖ The nurse educators have the responsibility to update the knowledge, attitude and practice of nursing students on knowledge and awareness about dementia.
- ❖ The finding of the study can serve as guidelines for the nurse educators for planning and conducting educational programme for student nurses regarding dementia.
- ❖ The nursing students should be made aware about their role in health promotion and disease prevention.
- ❖ The students should be motivated to make up innovational approaches to provide health education in different setting.

Implication for nursing administration

It helps the nursing administer to manage with mass group, how can conduct awareness programme to community and public. It help the nurse to learn how they can manage the problem if arise, organize the programme. It gives more aware about programme planning and planning for budget.

Implication for nursing research

It helps the student nurses to give idea to do research in effectiveness of various method of awareness regarding dementia. It gives idea to do research on dementia.

LIMITATIONS

- Structured teaching procedure was time consuming.
- Sample size was less to make any generalization.
- Limited to only elders.

PERSONAL EXPERIENCE

- The investigator has gained lot of new information and experience in many ways starting from the searching of research problem till the submission of the report.
- Apart from the struggle and tension, doing research was quite interesting and helpful.
- Investigator got unlimited literature review

RECOMMENDATIONS

- A similar study can be conducted in a large group of elders in community.
- The study can be replicated in different setting to strengthen the finding.

CONCLUSION

The following conclusions were drawn from the findings of the study. Structured teaching method is an effective method of giving information to people. This method helps to easy understanding and makes more awareness about dementia among elderly and caregivers; it helps to prevent development of dementia.

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APPENDIX-1

LETTER SEEKING PERMISSION TO CONDUCT MAIN STUDY

To,

Mrs. Mallika sundramoorthi,
Panchayat officer,
Palayakottai,
Nathakadaiyur(Via),
Kangayam(Tk),
Thirupur(Dt).

Respected Madam/ Sir,

Greetings from Shivparvathi Mandradiar Institute of Health Science, Tirupur.

Sub: Requisition to avail the permission to conduct Project – Regarding.

This is to certify that 3011231852 is a bonafied student of our college studying M.Sc. Nursing II- Year in the academic year of 2013- 14. As part of the M.Sc Nursing curriculum prescribed by the Tamilnadu Dr. M.G.R.Medical University, Chennai, he needs to conduct a project and he is willing to do at your esteemed institution. So, kindly do the needful and grant her permission to conduct the study.

The details of the project will be briefed to you by him in person.

Thanking you

Yours sincerely,

(Principal)

APPENDIX - 2

LETTER REQUESTING SUGGESTION FOR ESTABLISHING CONTENT VALIDITY

From,

301231852,
II Year M.Sc (N),
Shiv Parvathi Mandradiar Institute of Health Sciences,
Palayakottai, Tirupur.

To,

_____,
_____,
_____.

THROUGH,

The Principal,
Shiv Parvathi Mandradiar Institute of Health Sciences,
Palayakottai, Tirupur.

Respected Sir/Madam,

Subject: Letter requesting opinion and suggestions from experts for establishing content validity of tool...Regarding

I am II Year M.Sc Nursing student in Shivparvathi Mandradiar Institute of Health Sciences. As a partial fulfillment of Masters Degree in Nursing, I have selected the topic mentioned below for the research project to be submitted to "The Tamil Nadu Dr. M.G.R. Medical University Chennai". **Topic: "A quasi experimental study to assess the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in a selected village at Tirupur(Dt)".**

I kindly request you to validate the following enclosure and give your expert opinion and suggestions for necessary modifications of the tool.

Thanking you in Anticipation

Place: Yours sincerely,

Date:

(30111273)

Enclosed here with: 1.Proposal,

2. Tool

APPENDIX - 3

CONTENT VALIDITY CERTIFICATE

I hereby certify that I have validated the tool of 301231852 M.Sc Nursing student is undertaking "A quasi experimental study to assess the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in a selected village at Tirupur(Dt)".

Signature of the Expert :

Name :

Designation :

Date :

APPENDIX – 4

LIST OF EXPERTS

1. **Dr. Muniraju,MBBS, DPM,**
   Psychiatrist, Government Head Quarters Hospital
   Erode.

2. **Mr. T. Jaya Kumar M.Sc(N),**
   Associate Professor,
   Vivekandha College of Nursing,
   Tiruchancode.

3. **Mrs. Deepa.K M.Sc (N)**
   Reader,
   Dr. Mahalingam College of Nursing,
   Erode.

4. **Mrs. Manjula Devi. S M.Sc(N),**
   Reader,
   Nanda College of Nursing,
   Erode.

5. **Ms. Jothimani. M.Sc(N),**
   Lecturer,
   SPMIHS,
   Palayakottai.

6. **Mrs. Prathiba M.Sc, M.Phil,**
   Clinical Psychologist
   Erode.

APPENDIX – 5

INFORMED CONSENT FORM

I understand that I am being asked to participate in a research study conducted by 301231852, M.Sc(N) student of Shivparvathi Mandradiar Institute of Health Sciences. This research study will evaluate the "To assess the effectiveness of structured teaching program on the level of knowledge regarding dementia among elderly in a selected village at Tirupur(Dt)".

If I agree to participate in the study, I will be interviewed. The interview may be recorded and will take place in privacy. No identifying information will be included when the interview is transcribed. I understand that there are no risks associated with this study.

I realize that the knowledge gained from this study may help either me or other people in the future. I realize that my participation in this study is entirely voluntary, and I may withdraw from the study at any time I wish. If I decide to discontinue my participation in this study, I will continue to be treated in the usual and customary fashion.

I understand that all study data will be kept confidential. However, this information may be used in nursing publication or presentations. If I need to, I can contact 301231852 M.Sc (N) student of Shivparvathi Mandradiar college of Nursing, Palayakottai, Tirupur any time during the study (Ph.no: 8122603290).

The study has been explained to me. I have read and understood this consent form, my entire question has been answered, and I agree to participate. I understand that I will be given a copy of this signed consent form.

Signature of the participant: Date:

Signature of the investigator: Date:

APPENDIX -6

STRUCTERED TEACHING PROGRAMME ON DEMENTIA

INTRODUCTION

Dementia is a broad category of brain diseases that cause long term loss of the ability to think and reason clearly that is severe enough to affect a person's daily functioning. For the diagnosis to be present it must be a change from how the person was previously.

The most common form of dementia is Alzheimer's disease (75%). Other forms include Lewy body dementia, vascular dementia, frontotemporal dementia, progressive supranuclear palsy, corticobasal degeneration, normal pressure hydrocephalus and Creutzfeldt–Jakob disease. Except for a few treatable types in most cases there is no cure.

DEFINITION

Dementia is an acquired global impairment of intellect, memory and personality but without impairment of consciousness.

EPIDIMIOLOGY

Disability-adjusted life year for Alzheimer and other dementias per 100,000 inhabitants in 2002. Dementia becomes more common with age. While only 3% of people between the ages of 65–74 have dementia, 47% of people over the age of 85 have some form of dementia. As more people are living longer, dementia is becoming more common.

The number of cases of dementia worldwide in 2010 was estimated at 35.6 million. Rates increase significantly with age, with dementia affecting 5% of the population older than 65 and 20–40% of those older than 85. Around two thirds of individuals with dementia live in low and middle income countries, where the

sharpest increases in numbers are predicted. Rates are slightly higher in women than men at ages 65 and greater.

CAUSES OF DEMENTIA

Dementia has many different causes, some of which are difficult to tell apart. Many medical conditions can cause dementia symptoms, especially in older people.

The causes of dementia include various diseases such as

- infections
- strokes
- head injuries
- drugs, and
- Nutritional deficiencies.

All dementias reflect dysfunction in the cerebral cortex, the part of the brain that controls perception, memory, thoughts, language, and consciousness.

Aging of dementia

Almost 40 % of people over the age of 65 experience some form of memory loss. Age-associated memory impairment and dementia can be told apart in a number of ways. In general, a memory problem may become a concern if it begins to affect day-to-day living. Older adults do not go on to develop Alzheimer's disease or other dementia.

TYPES OF DEMENTIA

1. ALZHEIMER'S DISEASE

This is the most common cause of dementia. During the course of the disease, the chemistry and structure of the brain changes, leading to the death of brain cells.

2. VASCULAR DEMENTIA

If the oxygen supply to the brain fails, brain cells may die. The symptoms of vascular dementia can occur either suddenly, following a stroke, or over time, through a series of small strokes.

3. **DEMENTIA WITH LEWY BODIES**

This form of dementia gets its name from tiny spherical structures that develop inside nerve cells. Their presence in the brain leads to the degeneration of brain tissue.

4. FRONTO-TEMPORAL DEMENTIA

In fronto-temporal dementia, damage is usually focused in the front part of the brain. Personality and behavior are initially more affected than memory.

5. KORSAKOFF'S SYNDROME

Korsakoff's syndrome is a brain disorder that is usually associated with heavy drinking over a long period. Although it is not strictly speaking a dementia, people with the condition experience loss of short term memory.

SIGNS AND SYMPTOMS

The signs used to compile this list are published by the American Academy of Family Physicians (AAFP) in the journal American Family Physician:

- **Recent memory loss** - a sign of this might be asking the same question repeatedly, forgetting about already asking it.
- **Difficulty completing familiar tasks** - for example, making a drink or cooking a meal, but forgetting and leaving it.
- **Problems communicating** - difficulty with language by forgetting simple words or using the wrong ones.

- **Disorientation** - with time and place, getting lost on a previously familiar street close to home, for example, and forgetting how they got there or would get home again.
- **Poor judgment** - Even a well person might get distracted and forget to watch a child for a little while. People with dementia, however, might forget all about the child and just leave the house for the day.
- **Misplacing things** - including putting them in the wrong places and forgetting about doing this.
- **Mood changes** - unlike those we all have, swinging quickly through a set of moods.
- **Personality changes** - becoming irritable, suspicious or fearful, for example. Loss of initiative - showing less interest in starting something or going somewhere. Disinhibition and impulsivity.
- Depression or anxiety
- Agitation
- Balance problems
- Tremor
- Speech and language difficulty
- Trouble eating or swallowing
- Delusions (often believing people are stealing from them)
- Hallucinations
- Wandering or restlessness

DIAGNOSIS

1. ASSESSING MENTAL ABILITIES TO DIAGNOSE DEMENTIA

Questionnaires are often used to help test the mental abilities of the person with symptoms of dementia, and how severe they are. One widely used test is the mini mental state examination (MMSE). The MMSE assesses a number of different mental abilities, including:

- short- and long-term memory
- attention span
- concentration
- language and communication skills
- ability to plan
- ability to understand instructions

2. BLOOD TESTS FOR DEMENTIA

A person with suspected dementia may have blood tests to check their overall level of health and to rule out other conditions that may be responsible for their symptoms, such as thyroid hormones and vitamin B12 levels.

3. DEMENTIA BRAIN SCANS

Several types of brain scan can be used to help diagnose dementia:

A. Computerized tomography (CT) scan

A computerized tomography (CT) scan can be used to check for signs of stroke or a brain tumor.

B. Magnetic resonance imaging (MRI) scan

An MRI scan can provide detailed information about the blood vessel damage that occurs in vascular dementia, plus any shrinking of the brain (atrophy). In Alzheimer's disease, the whole brain is susceptible to shrinking, whereas in frontotemporal dementia the frontal and temporal lobes are mainly affected by shrinking.

OTHER SCANS AND PROCEDURES

Other types of scan, such as a

- Single photon-emission computed tomography (SPECT) scan.
- Positron emission tomography (PET) scan.
- In some cases, an electroencephalogram (EEG) may be taken to record the brain's electrical signals (brain activity).
- A lumbar puncture may also be used to check the protein levels in the brain. This procedure involves taking a sample of spinal fluid from the lower back for testing.

MANAGEMENT

Educating and providing emotional support to the caregiver is of importance as well. Exercise programs are beneficial with respect to activities of daily living and potentially improve dementia.

Psychological therapies

Psychological therapies which are considered as a treatment for dementia include

- **music therapy** ; Music Therapy is an established health profession in which music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals. After assessing the strengths and

needs of each client, the qualified music therapist provides the indicated treatment including creating, singing, moving to, and/or listening to music (eg). A person with Alzheimer's listening to an iPod with headphones of his/her favorite songs

- **reminiscence therapy** ; A psychotherapeutic technique in which self-esteem and personal satisfaction are restored, particularly in older persons, by encouraging patients to review past experiences of a pleasant nature
- **cognitive reframing ;** The process of replacing maladaptive thought patterns with constructive thoughts and beliefs
- **Mental exercise.**
    - Read as much as you can
    - Increase your vocabulary
    - Write something
    - Learn a new Language
    - Post-problem solve
    - Turn off the television
    - Talk with people.
    - Switch your dominant hand.

Medications

Currently, no medications have been shown to prevent or cure dementia. Medications maybe used to treat the behavioral and cognitive symptoms and have no effect on the underlying pathophysiology.

- **Acetylcholinesterase** inhibitors, such as donepezil, may be useful for Alzheimer disease and dementia in Parkinson's, DLB, or vascular dementia.
- **Antipsychotic drugs** should be used to treat dementia only if non-drug therapies have failed to be effective and the person's actions threaten themselves or others. Aggressive behavior changes are sometimes the result of other solvable problems that could make treatment with antipsychotics unnecessary.

- **N-methyl-D-aspartate (NMDA)** receptor blockers such as memantine may be of benefit but the evidence is less conclusive than for AChEIs. Due to their differing mechanisms of action memantine and acetylcholinesterase inhibitors can be used in combination however the benefit is slight.

- **Antidepressant drugs:** Depression is frequently associated with dementia and generally worsens the degree of cognitive and behavioral impairment. Antidepressants effectively treat the cognitive and behavioral symptoms of depression in patients with Alzheimer's disease, but evidence for their use in other forms of dementia is weak.

REGULAR EXERCISE

The benefits of regular exercise, is essential in treating Alzheimer's and dementia:

- Reduces stress
- Boosts mood
- Improves memory
- Increases energy

HEALTHY DIET

Eat to protect glial cells. It may help remove debris and toxins from the brain that can contribute to Alzheimer's disease. Consuming foods such as ginger, green tea, fatty fish, soy products, blueberries, and other dark berries may protect these important cells from damage.

QUALITY SLEEP

The vast majority of elders need at least 8 hours of sleep per night. Any less, and productivity and creativity suffers.

Tips to help you combat insomnia and catch up on dementia,

- Establish a regular sleep schedule.
- Be smart about napping.
- Set the mood.
- Create a relaxing bedtime ritual.
- Quiet your inner chatter.

STRESS MANAGEMENT

Stress that is chronic or severe takes a heavy toll on the brain, leading to shrinkage in a key memory area of the brain known as the hippocampus, hampering nerve cell growth, and increasing your risk of Alzheimer's disease and dementia. Yet simple daily tools can minimize its harmful effects.

- Take deep Breathe
- Schedule daily relaxation activities.
- Nourish inner peace.

AN ACTIVE SOCIAL LIFE

- Volunteer
- Join a club or social group
- Visit your local community center or senior center
- Take group classes (such as at the gym or a community college)
- Reach out over the phone or email
- Get to know your neighbors

Make a weekly date with friends

ALTERNATIVE MEDICINE

Other therapies that have been studied for effectiveness include aromatherapy with slight evidence, massage with unclear evidence

Aromatherapy is the therapeutic use of plant-derived, aromatic essential oils to promote physical and psychological well-being. It is sometimes used in combination with massage and other therapeutic techniques as part of a holistic treatment approach.

PREVENTION

1. Eat more fruits and vegetables
2. Reach for berries

Berries contain high levels of biologically active components, including a class of compounds called anthocyanosides, which fight memory impairment associated with free radicals and beta-amyloid plaques in the brain. Eat berries each day for maximum benefit

3. Take folic acid supplements

If you don't take a supplement, eat foods high in folate. High levels of homocysteine may be associated with poor cognitive function. Some findings indicate that reducing homocysteine with folic acid may increase cognitive function

4. Sip smarter

Drink a glass of red wine or purple grape juice with your evening meal. Components in grape skins protect brain cells from the toxic effect of oxidative stress and beta amyloid.

5. Go Mediterranean

- Two studies that used dietary questionnaires to assess and quantify adherence to the diet in different populations found that patients who were most adherent

to the Mediterranean style diet(Plant-based meals, with just small amounts of meat and chicken, when they are used More servings of grains, fresh fruits and vegetables, nuts, and legumes Plenty of fish and other seafood rather than red meat,Olive oil,Plenty of fish and other seafood rather than red meat) had a lower ihcidence of Alzheimer`s compared with those who did not follow this diet.

6. Control your blood pressure

Hypertension appears to be associated with an increased risk of both vascular dementia and Alzheimer's disease.

7. Have strong social support

Findings indicate that an active social life and strong network of friends may help prevent Alzheimer's in later life.

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APPENDIX – 7

SOCIO DEMOGRAPHIC DATA

INSTRUCTIONS

The researcher will ask Questions listed in the schedule using one to one technique. Kindly give the information regarding the following questionnaire. Please answer the questions by marking (√) to the option you feel relevant in the serial no

1) Age in years
    a. 60 – 63years
    b. 64- 66 years
    c. Above 66 years

2) Gender
    a. Male
    b. Female
    c. Transgender

3) Religion
    a. Hindu
    b. Muslims
    c. Christian
    d. others

4) Marital status
    a. Single
    b. Married
    c. Widower
    d. Divorce

5) Educational status
    a. Illiterate
    b. Primary education
    c. High school education
    d. Degree and above

6) Occupation
    a. Government employee
    b. Business man
    c. Private employee
    d. Cooley
    e. Retired/unemployed

7) Number of children
    a. No children
    b. One child
    c. Two children
    d. More than 2 children

8) Type of family
    a) Nuclear family
    b) Joint family
    c) Extended family

9) Family Income
    a. < Rs-5000/-
    b. Rs.5001- 10000
    c. Above Rs 10000

10) Hobbies

a. Reading books and news paper
b. Watching TV
c. Chatting with friends
d. None

11). A. Previous sources of information regarding Dementia

a. Yes
b. No

. B. if yes

a. Friends
b. Newspaper
c. Mass media

SECTION- II

STRUCTURED QUESTIONNIARE FOR ASSESSING THE KNOWLEDGE REGARDING DEMENTIA AMONG ELDERY

INSTRUCTIONS

The structured questionnaire contains 25 questions. Read each statement carefully and give your appropriate response by a tick mark to all the statement.

1. Dementia is
   a. Impairment of memory
   b. Impairment of intellect and memory
   c. Impairment of physical activity

2. Which type of memory loss occurs in dementia?
   a. Remote memory loss
   b. Immediate memory loss
   c. Recent memory loss

3. In dementia the person is disoriented to
   a. Time and place
   b. Person and object
   c. Colors and animals

4. Which one of the following is an indicator of dementia?
   a. Anorexia
   b. Drowsiness
   c. Mood swings

5. Which of the following age groups is most affected by in dementia?
   a. Above 60years
   b. 40 to 60years
   c. 50 to 60years

6. In which type of dementia, degeneration of brain tissue is seen
   a. Vascular dementia
   b. AIDS dementia
   c. Alzheimer's dementia

7. Which one of the following is a cause of dementia?
   a. Diabetes mellitus
   b. Nutritional deficiency
   c. Tuberculosis

8. Which clinical symptom is seen in later stage of dementia?
   a. Difficulty in word findings
   b. Confusion
   c. Loss of short and long term memory

9. A sign of recent memory loss is
a. Asking the same question repeatedly
b. Difficulty with language
c. forgetting time and place

10. Which one of following symptom identify by scan in dementia

   a. Stroke
   b. hemorrhage
   c. lesion

11. Which of the food item will improve the concentration in dementia?

a. Meat
b. Nuts
c. Beans

12. Which of these infectious disease induced dementia?

a. Sepsis
b. AIDS
c. UTI

13. Which type of support is needed in dementia person?

a. Social support
b. Emotional
c. Biological

14. In dementia patient there is an inability to

a. Express the skill
b. Express the feelings
c. Learn new task

15. Which of the following is a late stage challenge for a person with Alzheimer's disease?

a. Production of meaningful words
b. Social communication
c. Incontinence of bowel and bladder

16. In fronto temporal dementia a brain damage usually focused

a. front part of the brain
b. whole brain
c. half part of the brain

17. Korsakoff's syndrome is characterized by

a. Hyperactivity
b. Severe short term memory
c. Loss of speech

18. Which of the following is a warning sign of Alzheimer's dementia

a. Forgetfulness
b. Changes in personality
c. Difficulty in performing unfamiliar task

19. Which formal assessment is used in dementia?

a. Physical assessment
b. Mini mental assessment
c. Functional linguistic assessment

20. Which component of memory process is lacking in dementia?

a. Encoding
b. Retrieval
c. Storage

21. Reminiscence therapy is defined as

a. improve the self-esteem
b. improve the relaxation
c. encouraging the past experience

22. Which type of nutrition lead to continue in dementia?

a. Iron deficiency
b. VitaminB12 deficiency
c. Calcium deficiency

23. Which on of the following alternative medicine of dementia?
    a. Aromatherapy
    b. siddha
    c. homeopathy

24. Which one of the following factors induce dementia?
    a. hypertension
    b. Diabetes mellitus
    c. Tuberculosis

25. How long the elder need to sleep at night

    a. 8hours

    b. 5hours

    c. 9hours

ANSWER KEY

Question No.	Answer	Question No.	Answer
1.	a	14.	c
2.	a	15.	c
3.	a	16.	a
4.	c	17.	b
5.	a	18.	a
6.	a	19.	b
7.	b	20.	a
8.	c	21.	c
9.	a	22.	b
10.	a	23.	a
11.	b	24.	a
12.	b	25.	a
13.	a		

SCORING KEY

SCORING INTERPRETATION

- Maximum score-25
- Minimum score –0

0 -13	0 -50%	In adequate knowledge
13 -20	50 - 75 %	Moderately adequate knowledge
21 -25	> 75%	Adequate knowledge

நினைவாற்றல் பாதிப்பு விளக்கம் பற்றிய பயிற்சிமுறை

அறிமுகம்

நினைவாற்றல் குறைவு நோய் என்பது மூளை நோய்களில் ஒருவகை. முனிதனின் அன்றாட வாழ்க்கையில் உள்ள நிகழ்வுகள். சிந்திக்கும் திறன் குறைவு தான் இந்த நோயின் அறிகுறிகள். இந்த நோய்களில் பாதிப்பு அடைந்தவர்கள் இதற்கு முன்பு உள்ள நிலையில் இருந்து மாறுபட்டு இருப்பார்கள்.

பொதுவாக இந்நோய் 75சதவீதம் மறதிநோயில் வரும். மேலும் இந்த நோய் உருவாகுவதற்கு பார்கின்சன் நோய், மூளை இரத்த குழாய் சிதைவு, மூளைச்சதை சிதைவு, பக்கவாதம், உைறபோதலாமஸ் சிதைவு, மூளை வீக்கம், கிரெட்ஜ்பெல்ட் ஜெக்கப் நோய் போன்றவைகளால் வரும்.

வரையறை

நினைவாற்றல் குறைவு நோயானது சிந்தனைதிறன், நினைவாற்றல், பழக்கவழக்கம் ஆகியவற்றில் குறைபாடு ஏற்படும். ஆனால் நினைவிழத்தல் ஏற்படாது.

வரலாறு

பொதுவாக இந்நோயானது வயதானவர்களுக்கு வருகிறது. 3சதவீதம் மக்கள் 65-74 வயதிற்குட்பட்டவர்களே?

47சதவீத மக்கள் 85 வயதிற்கு மேற்பட்டவர்களே!

2002 ஆம் ஆண்டில் 100,000 நோயாளிகள் மறதிநோய் மற்றும் மற்ற நினைவாற்றல் குறைவு நோய்களால் பாதிக்கப்படுள்ளனர்.

35.6மில்லியன் மக்கள் நினைவாற்றல் குறைவு நோயால் உலகமுழுவதும் பாதிக்கப்பட்டுள்ளனர்.

வுயதானவர்களுக்கு இந்நோய் அதிகமாக உள்ளது என்பதை இக்கணக்கீடுகள் காட்டும்.

5சதவீத மக்கள் 65 வயதிற்கு மேற்பட்டவர்களே.

20-40சதவீத நோயாளிகள் 85 வயதிற்கு உட்பட்டவர்கள்.

மூன்றில் பங்கு நோயாளிகள் பொருளாதார பின்தங்கிய மற்றும் வளரும் நாடுகளை சார்ந்தவர்களே!

பெண்களுக்கே இந்நோயானது அதிகமாக வருகிறது. அதிலும் 65 வயதிற்கு மேல் உள்ளவர்களே!

காரணங்கள்

நினைவாற்றல் குறைவு நோய்க்கு நிறைய காரணங்கள் உள்ள மற்ற நோய்களாலும் வரக்கூடும்.

- பக்கவாதம்
- தலைக்காயம்
- மருந்துகள்
- சத்துகுறைவு (வைட்டமின் பி12)
- நோய் கிருமி தாக்கம்
- அனைத்து விதமான நினைவாற்றல் குறைவுகளும் மூளை சுற்றியுள்ள உரையின் செயல்பாட்டுத்திறன் குறைவதே ஆகும். ஆதாவது
- ஞாபகம், எண்ணம், திறனி அறிதல், மொழி, நினைவு போன்ற செயல்பாடுகளை குறைப்பதே ஆகும்.

வயது

- 40சதவீத மக்கள் 65வயதிற்கு மேற்பட்டவர்கள்.
- நிறைய வழிகளில் நினைவாற்றல் குறைவு வெளிப்படும் அன்றாட வாழ்க்கை செயல்பாடுகள் உணவுஉண்ணுதல், பழக்கவழக்கம், பேச்சு உரையாடல், போன்றவற்றில் மாற்றங்கள், மறதிகளும் காணப்படும்.
- இந்நோய் நாளுக்கு நாள் அதிகரித்து கொண்டேயிருக்கும்.

நினைவாற்றல் குறைவின் வகைகள்

மறதி நோய் (Alzneimes disease)

மறதி நோயில் நினைவாற்றல் குறைவு அதிகமாக ஏற்படும். மேலும் மூளையின் நரம்பு அமைப்பு வேதியியல் மாற்றங்களால் மூளை சிதைவு ஏற்படும். இதுவே மிகப்பெரிய காரணமாகும்.

இரத்த குழாய் சிதைவு மறதி நோய்

மூளை இரத்த குழாய் சிதைவு ஏற்படுவதால் மூளைக்கு சரியான இரத்த ஓட்டம் மற்றும் பிராண வாயு கிடைக்ககாததால் நரம்பு செல்கள் இழக்க நேரிடும். இதனால் மறதி ஏற்படும்.

பார்கின்சன் நோய்

நரம்பு செல்களின் உருவ அமைப்பு மற்றும் லெவி பகுதிகளின் சிதைவுகளால் ஏற்படும் மறதிநோய் இதில் பெரும்பாலும் மறதிநோய் ஏற்படும்.

கிரட்ஜ்பெல்ட் மறதி

இது ஒருவைகயான நரம்பு அமைப்பு குறைவு. புரத மூலக்கூறுகளில் தவறுதலாக நரம்பு செல்களில் தேங்குவதால் இக்குறைபாடு ஏற்படும்.

மரபு நோய்

குரோமோசோம் எண்ணிக்கை மாற்றங்களால் நரம்பு மற்றும் மூளை வளர்ச்சி குறைபாட்டால் மறதி நோய் ஏற்படும்.

மூளைச் சிதைவு

முன் மூளை மற்றும் நடுமூளை சிதைவினால் ஞாபகத்தை கட்டுப்படுத்தும் பகுதிகள் செயலிழக்க நேரிடும்.

கோர்சகாப் நோய்

நீண்ட கால மதுபழக்கத்தில் மூளைச் சிதைவு ஏற்பட்டு மறதி நோய் ஏற்படும். வைட்டமின் பி குறைவதனால் ஏற்படுகிறது.

ஊறான்டின்ங்டன் நோய்

இதுவும் மரபணு குறைபாடுகளால் ஏற்படும் நோய். இதில் மூளையில் நடுப்பகுதியல் முற்றிலுமாக செயலிப்பு ஏற்படுத்தும். இதனால் மறதி நோய் மிக தீவிரமாக வரும்.

தலைக்காய மறதி நோய்

இது அனைத்து வயதினர்களுக்கு ஏற்படும் குறைபாடு, தலைக்காயம் ஏற்படுவதால் வருகிறது.

உணவுக் குறைப்பட்டு மறதி நோய்

உணவில் வைட்டமின் பி சத்து குறைவதால் தேவையான ஊட்டச்சத்து மூளைக்கு கிடைக்காததால் மறதி குறைபாடு ஏற்படும்.

அறிகுறிகள்

- தற்சமய மறதி : தொடர்ந்து ஒரே கேள்வியையே கேட்டுக் கொண்டே இருப்பது. (முதலில் சொன்ன பதில் மறந்து விடுவது)
- அன்றாட பழக்க வழக்க மறதி: சாதாரண வேலைபாடுகளால் சமைத்தல், உணவு உண்ணுதல், நீர் அருந்துதல் போன்றவற்றில் குறைபாடு ஏற்படும்.

பேச்சாற்றல் குறைதல்

- பேசுவதில் குறைபாடு அதாவது நன்கு தெரிந்த பழக்கமான வார்த்தைகள் சொல்கள் மறந்து போகுதல்.
- இடங்கள், நேரம் பற்றிய விழிப்புணர்வு இல்லாமை, வழக்கமான இடங்களின் பெயர்கள், செல்லும் வழி ஆகியவை மறந்து போகுதல்.
- தப்பாக புரிந்துகொள்ளுதல் சிறிய விசியங்களையும் மிகப்பெரிதாகவோ, தவறாகவோ புரிந்து கொள்ளுதல்.
- மாற்றி பொருட்களை வைத்துவிட்டு தேடுவது.
- முனநிலை அவ்வப்போது மாறிக்கொண்டே இருக்கும் திடீரென்று கோபப்படுதல், சிரித்தல் போன்றவை.
- குணநலன்கள் மாறுவது அதாவது ஆர்வம் குறைதல், பழக்கவழக்கங்கள் மாறுதல், பயப்படுதல், சிறிய செயல்களுக்கு மிகப் பெரியதாக கவலைப்படுதல்.
- மனஅழுத்தம் யாருடனும் பேசாமல், பழகாமல், அமைதியாகவும், சோகமாக, சோர்வாக, இறப்பு குறித்து பேசுதல்.
- சுரிநிகர் சமான சிந்தனைகள் குறைதல்.
- நடுக்கம்.
- சாப்பிடுதல், முழங்குவதில் தொந்தரவு.
- மாற்றமுடியாத அவநம்பிக்கைகள்.
- பதட்டம்.

கண்டறிதல்

வினா விடை மூலம் மிகவும் சிறப்பாக இந்நோயை கண்டறியலாம். மிக பிரபலமாக பயன்படுத்தும் முறை ஆகும்.

- நீண்ட குறுகிய கால நினைவாற்றல்
- கவனச்சிதறல்
- ஒருமுனைப்படுத்துதல்
- மொழித்திறன்
- பேசும்திறன்
- புரிந்து கொள்ளும் திறன்
- ஆயத்தப்படுத்தும் திறன்

இரத்த பரிசோதனை

- பொதுவாக நமது உடலில் மூளை செயல்திறனை பாதிக்கும் நோய்கிருமிகள் கண்டறியலாம்.
- மூளைக்கு தேவையான வைட்டமின் பி சத்தின் அளவு, தைராய்டின் அளவு கண்டறியலாம்.
- நோயின் காரணத்தை பொறுத்து இரத்த பரிசோதனை செய்யலாம்.

ஸ்கேன்

மூளைச் சிதைவு மற்றும் நரம்பு மண்டல குறைபாடுகள், கட்டி கேன்சர் போன்ற காரணங்களால் ஏற்படும் மறதிக்கு சிடி ஸ்கேன் பெரிதும் உதவும்.

எம்ஆர்ஐ ஸ்கேன்

இந்த ஸ்கேன் ஆனது மூளையில் சதைப்பகுதியில் இரத்த குழாய் சுருங்குதல், வெடித்தல், இரத்தம் கெட்டிபோதல் ஆகியவற்றை கண்டறியலாம்.

- ஸ்பெக்ட் ஸ்கேன்
- பேட் ஸ்கேன்
- லேகட்ரோ என்செபலோகிராபி (மூளை செயல் திறனை கண்டறிதல்)
- மூளைத்தண்டுவட திரற பரிசோதனை (புரதகுறைபாடுகளை கண்டறிதல்)
- நோய் தொற்றுகளை கண்டறிதல்

மருத்துவசிகிச்சை

முதலில் இந்நோயாளிகளுக்கு மன ஆறுதல், நம்பிக்கையையும், புத்துணர்ச்சியை தரவேண்டும்.

ஊளவியல் ரீதியான சிகிச்சைகள்:

இசை சிகிச்சை

நல்ல இசைகளை கேட்க வைப்பதனால் அவர்களின் குணநல, பழக்கவழக்க, கடவுள், மனதாலும், உடலாலும் எவ்வாறு நலமாக இருக்கிறார்களான என அறியலாம் எவ்வகை இசை கேட்கிறார்கள் மூலம் தற்போதைய மனநலம் எவ்வாறு இருக்கிறது என்பதை அறியலாம். மேலும் இசை கேட்ட பிறபு அவர்கள் எவ்வாறு உணர்கிறார்கள் என்பதை அறிந்து நல்ல பழக்கங்கள் மற்றும் குணங்களை ஊக்கப்படுத்தலாம். மேலும் பழைய கால வாழ்க்கையை ஞாபகப்படுத்தலாம்.

தன்னம்பிக்கை ஊட்டல்

நம்பிக்கை, கொள்கைகளை உருவாக்க வழிசெய்தல், வயதினர் ஞாபக மறதியுள்ளவர்கள் பெரும்பாலும் தன்னால் இனி எதுவும் செய்ய இயலாது. நாம் பிறருக்கு பாரமாகி விட்டோமோ என்ற நம்பிக்கையின்மையில் சோர்வாக இருப்பர். ஆதனால் சிறிய செயல்களை செய்ய வைத்தல், ஞாபகமூட்டல் வழிகளை சொல்லி கொடுப்பதன் மூலம் அவர்களின் செயல்திறனை அதிகப்படுத்தலாம்.

சிந்தனைத்திறனை அதிகப்படுத்துதல்

- பேசும்போது மறந்தவற்றை மீண்டும் ஞாபகப்படுத்த குறிப்பு சொல்களை கூறுவது.
- எண்ணங்களை வெளிப்படுத்த செய்வது.
- கவனச்சிதறல் இல்லாமல் ஒருமுறைப்படுத்த உதவுவது.
- மிகஎளிய வார்த்தைகளை உபயோகப்படுத்தி பேசுவது, பேச செய்வது.

மன நலப்பயிற்சி

- படிக்க வைத்தல், அதை விவரித்து சொல்ல வைத்தல்.
- பேரிய சொற்கோவையை உச்சரிக்கவைத்தல், அதிகமாக படிக்க வைத்தல்.
- எதையாவது எழுதச் சொல்வது அதைப்பற்றி விவரமாக பேச வைப்பது.
- புதிய மொழிகளை கற்றல்.

- பிற மனிதர்களிடம் பேச வைத்தல் மற்றும் பழைய நிகழ்வுகள், மனிதர்களை பற்றி பேசவைத்தல்.
- பிரச்சனைகளுக்கு தீர்வு கண்டுபிடிக்க சொல்லுதல்.

மருந்து முறைகள்

மறதியை குணப்படுத்த மருந்துகள் இல்லை ஆனால் குணநல மற்றும் சிந்தனை குறைபாடுகளை தீர்க்க மருந்துகள் உள்ளன.

ஆசிடைல்கோலின்ஸ்ரேஸ் தடுப்பு மருந்துகள்

எ.கா: டோனிபிசில் எனும்மருந்து பொதுவாக அல்சீமியரீ, பர்கின்சன், லெவி மறதி, இரத்த குழாய் மறதி நோய்க்கு கொடுக்கப்படுகிறது.

முனநலக்குறைவு தீர்க்கும் மருந்துகள்

- குணநலக்குறைபாடுகளுக்கு பயன்படுத்தப்படும் மருந்துகள் கொடுக்கலாம்.
- என்மெத்தில்-டி அஸ்பார்டேட் தடுப்புகள்: எ.கா: மெமன்டின்

மனஅழுத்தத்தை குறைக்கும் மருந்துகள்

மன அழுத்தத்தை குறைக்கும் மருந்துகள் பயன்படுத்தலாம்.

உடற்பயிற்சி

தினமும் உடற்பயிற்சி செய்வதன் மூலம் மனஅழுத்தம் குறையும். மனதை புத்துணர்ச்சி கொடுத்தல் நினைவாற்றலை அதிகப்படுத்துதல், ஆற்றலை அதிகரித்தல்.

சத்தான உணவு வகைகள்

இஞ்சி, பச்சை டி, மீன், காலை உணவுகள், கரு திராட்சை, அடர்நிற பழங்கள் அனைத்தும் மூளையில் உள்ள இறந்த செல்களை நீக்கி புதிதாக செல்களை உருவாக்கும்.

வைட்டமின் பி நிறைந்த உணவுகளை உண்ணுதல் நரம்பு செல்களுக்கு புத்துணர்ச்சி தரும்.

தூக்கப் பயிற்சி

- வயதானவர்கள் சரியாக 8 மணிநேரம் தூங்க வேண்டும்.
- அன்றாட அட்டவணை வகுத்தல்.
- தவறாமல் தூங்க சரியான நேரத்திற்கு வரும்.
- மன அமைதியை காத்தல்.
- தூங்க செல்லும் முன் மன அமைதிப்படுத்துதல்.

மன அழுத்தத்தை குறைக்கும் பயிற்சி

- மூச்சிப்பயிற்சி
- இசை கேட்டல்
- செடிகளுக்கு தண்ணீர் பாய்ச்சல்.
- நல்ல படங்களை பார்க்க வைத்தல்.

சமூக வாழ்க்கை

- சமுதாய சங்கங்களில் சேர்தல்.
- அருகில் உள்ள இடங்களுக்கு செல்லுதல்.
- தொலைபேசி இணையதளங்களை உபயோகித்தல்.
- நிகழ்ச்சிகளில் கலந்து கொள்ளுதல்.
- அருகில் அக்கம் பக்கத்தினரிடம் பழகுதல்.
- நண்பர்களை வரவழைத்தல், உரையாடுதல், வெளியே சென்று வருதல்.

மாற்றுசிகிச்சை முறை: (Alternative Rx)

வாசனைப்தெரபி: நல்ல வாசனைகளை நுகர வைத்தல், தாவரங்கள், மலர்கள், எண்ணெய் திரவியங்களை நுகர வைப்பதன் மூலம் மனதை அமைதிப்படுத்த செய்யலாம்.

தடுப்பு முறைகள்

நிறைய பழங்கள் காய்கறிகளை உண்ணுதல், பொதுவாக மஞ்சல் மற்றும் ஆரஞ்சு நிற காய்கறி பழங்கள்.

பெரி பழங்கள் அந்தோசையனோசைட் எனும் பொருளானது ஞாபக சக்தியை அதிகப்படுத் உதவும். இது சென்று மூளைநரம்பு முடிச்சு சார்ந்த நோய்களை தீர்க்க வல்லது.

போலிக் ஆசிட் : வைட்டமின் பி

வைட்டமின் பி நிறைந்த உணவுகள் ஹோமோசிஸ்டைன் சார்ந்த சிந்தனைதிறன் குறைதலை தீர்க்க வல்லது.

இரவு நேரங்களில் உணவுடன் சிறிது திராட்சை பழச்சாறு அருந்துவது நல்லது. மூளையில் நரம்பு செல்களில் ஆபத்து விடைவிக்கும் நச்சுகளை வெளியேற்றும்.

தியானப்பயிற்சி

காய்கறி, தானியங்கள், பழங்கள், விதைகள், தண்டுகள், மீன், கடல் உணவுகள், சிறிது ஆட்டுக்கறி, கோழிக்கறி, ஆலிவ் எண்ணெய் உண்ணுதல் நல்லது.

உயர் இரத்த அழுத்தத்தை கட்டுபாட்டில் வைத்தல் கோபத்தை குறைத்தல், இரத்த அழுத்தத்தை கட்டுப்படுத்தும் மருந்து எடுத்துக் கொள்ளுதல்.

குடும்ப உறுப்பினர்கள் தரும் அன்பும் அரவணைப்புமே மிகச் சிறந்த சிகிச்சை.!

பகுதி-I

நான் உங்களிடம் கேட்கும் கேள்விகள் கீழே வரிசைப்படுத்தப்பட்டுள்ளது. தயவு செய்து, நான் உங்களிடம் கேட்கும் கேள்விகளுக்கு சரியான பதிலை, சரியா (அல்லது) தவறா என்ற முறையில் பதில் அளிக்கவும்.

1. வயது

    அ. 60 முதல் 63 வருடம் வரை

    ஆ. 64 முதல் 66 வருடம் வரை

    இ. 66 வருடத்திற்கு மேல்

2. பாலினம்

    அ. ஆண்

    ஆ. பெண்

    இ. திருநங்கை

3. மதம்

    அ. இந்து

    ஆ. முஸ்லீம்

    இ. கிறிஸ்துவர்

4. திருமண நிலை

அ. திருமணம் ஆகாதவர்

ஆ. திருமணம் ஆனவர்

இ. விதவை

ஈ. விவாகரத்து ஆனவர்

5. கல்வி தகுதி

அ. படிக்காதவர்

ஆ. முதல் நிலை கல்வி மட்டும்

இ. மேல்நிலை கல்வி மட்டும்

ஈ. பட்ட படிப்பு மற்றும் அதற்கும் மேல்

6. வேலை

அ. அரசு பணியாளர்

ஆ. வாணிகம் செய்பவர்

இ. தனியார் பணியார்

ஈ. கூலி வேலை செய்பவர்

7. எத்தனை குழந்தைகள்

அ. குழந்தைகள் எதுவுமில்லை

ஆ. ஒரு குழந்தை மட்டும்

இ. இரண்டு குழந்தைகள்

ஈ. இரண்டு குழந்தைகளுக்கு மேல்

8. குடும்ப நிலை

அ. கூட்டு குடும்பம்

ஆ. தனியார் குடும்பம்

9. குடும்ப வருமானம்

அ. ரூ.5,000 கீழே

ஆ. ரூ.5,000 முதல் ரூ10,000 ரூபாய்க்குள்

இ. ரூ.10,000க்கு மேல்

10. பொழுமுபோக்கு அம்சங்கள்

அ. புத்தகம் மற்றும் செய்திகள் வாசித்தல்

ஆ. தொலைகாட்சி பார்த்தல்

இ. நண்பர்களிடம் பேசிக்கொண்டு இருந்தல்

ஈ. எதுவுமில்லை

11. A. நீங்கள் வயது முதிர்வு நிலையில் சிந்திக்கும் திறன் குறைவு பற்றி அறிந்திருக்கிறீர்களா? உங்கள் பதிலை ஆம் (அ) இல்லை என்ற முறையில் கூறவும்.

அ. ஆம்

ஆ. இல்லை

B. ஆம் என்றால், கீழே உள்ளவைகளில் எவற்றின் மூலம் அறிந்துகொண்டீர்கள்?

அ. நண்பர்கள்

ஆ. செய்தித்தாள்

இ. வானொலி, தொலைக்காட்சி மற்றும் இணையதளம்

ஈ. மேற்கூறிய அனைத்தின் மூலம்

நினைவாற்றல் பாதிப்பு

பின்வரும் விரிவான கேள்விகளுக்கு சரியான பதில்களை குறிப்பிடுக.

1. சிந்திக்கும் திறன் நினைவாற்றல் பாதிப்பு என்றால் என்ன?

   அ. நினைவற்றால் பாதிப்பு

   ஆ. உடல் செயல்படும் திறன் பாதிப்பு

   இ. சிந்திக்கும் திறன் மற்றும் நினைவாற்றல் பாதிப்பு

2. எந்த வகை ஞாபக மறதி இந்நோயினால் ஏற்படும்?

   அ. நாள்பட்ட ஞாபக மறதி

   ஆ. தற்காலிக ஞாபக மறதி

   இ. உடனடி ஞாபக மறதி

3. இந்த நோயுள்ள நபர் கீழ்கண்ட எவற்றுள் குழப்பம் அடைவார்?

   அ. இடமும் காலமும்

   ஆ. பொருளும் நபரும்

   இ. நிறங்களும் விலங்குகளும்

4. கீழ்கண்டவற்றுள் இந்த நோயின் அறிகுறி எது?

   அ. பசியின்மை

   ஆ. பறக்கும் மனநிலைமை

   இ. தூக்கமாக இருந்தல்

5. கீழ்கண்டவற்றுள் எந்த வயது வரம்பினர் இந்த நோயினால் பாதிக்கப்படுவர்?

அ. 60- வயதிற்கும் மேல்

ஆ. 40 - 50 வரை

இ. 50 - 60

6. எந்த வகை நினைவு ஆற்றல் பாதிப்பில் மூளை திசுக்களில் பாதிப்பு ஏற்படும்?

அ. இரத்த நாளம்

ஆ. எய்ட்ஸ்

இ. அல்ஜீமாஸ்

7. கீழ்கண்டவற்றுள் இந்நோயின் மூலக்காரணம் எது?

அ. சர்க்கரை வியாதி

ஆ. உணவு சத்து குறைபாடு

இ. காச நோய்

8. இந்நோயினால் பாதிக்கப்பட்டவர்க்கு பின்நாளில் ஏற்படும் அறிகுறிகள் எது?

அ. வார்த்தை கண்டுபிடிப்பில் சிரமம்

ஆ. குழப்பம்

இ. குறுகிய மற்றும் நீண்ட கால ஞாப மறதி

9. தற்காலிக ஞாபக மறதியின் அறிகுறி எது?

அ. ஒரே கேள்வியை திரும்ப திரும்ப கேட்பது

ஆ. மொழி தடுமாற்றம்

இ. இடம் காலம் மறப்பது

10. இந்த நோயினால் உள்ளுறுப்பு படம் மூலம் அறியப்படும் அறிகுறி எது?

அ. பக்கவாதம்

ஆ. இரத்தகசிவு மூளை

இ. கட்டி மூளை

11. கீழ்கண்டவற்றுள் எந்த வகை உணவுபொருள் இவ்வியாதியின் தன்மையை அதிகப்படுத்தும்?

அ. இறைச்சி

ஆ. கொட்டை வகைள்

இ. பட்டாணி

12. கீழ்கண்டவற்றுள் எந்த நோய் இவ்வியாதியை உண்டுபண்ணும்?

அ. எய்ட்ஸ்

ஆ. இருதய நோய்

இ. சிறுநீர் நோய்

13. இந்நோயினால் பாதிக்கப்பட்டவர்களுக்கு எவ்வகையான ஆதரவு தேவைப்படுகிறது?

அ. சமுதாய ஆதரவு

ஆ. மனநல ஆதரவு

இ. உயிரியல் சார்ந்த ஆதரவு

14. இவ்வகை நோயினருக்கு எவ்விதமான இயலாமை இருக்கும்?

அ. புதியன கற்றல்

ஆ. உணர்வு வெளிப்படுத்தல்

இ. திறமை வெளிப்படுத்தல்

15. அல்ஜீமர்ஸ் வியாதியினருக்கு பிற்காலத்தில் ஏற்படக்கூடிய சவால் எது?

அ. அர்த்தமுள்ள வார்த்தைகளை கண்டுபிடித்தல்

ஆ. சமுதாயத்தில் பங்கேற்றல்

இ. சிறுநீர் மற்றும் மலம் கட்டுபாடின்றி இருத்தல்

16. பிராண்டோ டெம்போரோ இவ்வகையில் மூளைப் பாதிப்பு எப்பகுதியை உணர்த்தும்?

அ. முன்பகுதி

ஆ. மூளை முழுவதும்

இ. பாதி மூளைப்பகுதி

17. சோர்சகோப்ஃ என்றால் என்ன?

அ. அளவுகடந்த செயல்

ஆ. தீவிர குறுகிய மறதி

இ. பேச்சாற்றலின்மை

18. அல்ஜீமர்ஸ் நோயினால் ஏற்படும் அபாய அறிகுறி என்ன?

அ. மறதி

ஆ. புதியன செய்வதில் சிரமம்

இ. இயல்புத் தன்மை மாற்றம்

19. இவ்வகை நோயினருக்கு எவ்வகையான மதிப்பீடு மேற்கொள்ளப்படுகிறது?

அ. உடல் செயற்பாடு மதிப்பீடு

ஆ. மனநல மதிப்பீடு

இ. மொழிவாரியான மதிப்பீடு

20. இந்த நோயினால் தாக்கப்படுவர்களுக்கு எந்த வகையான ஞாபக முறையில் பாதிப்பு ஏற்படுகிறது?

அ. தகவல் மாற்றி அமைத்தல்

ஆ. தகவல் மீண்டும் பெறுதல்

இ. தகவல் பாதுகாப்பு

21. நினைவு கூர்தல் சிகிச்சை முறை என்பது எது?

அ. தன்னம்பிக்கையை ஊக்குவிப்பது

ஆ. பொழுது போக்கு செயலை ஊக்குவிப்பது

இ. கடந்த கால அனுபவங்களை நினைவுகூர்வது

22. எவ்வனையான உணவுக் குறைபாடு இந்நோயினால் தொடர்ந்து காணப்படும்?

அ. இரும்புச்சத்து குறைபாடு

ஆ. வைட்டமின் டீ12 குறைபாடு

இ. கால்சியம் சத்து குறைபாடு

23. கீழ்கண்டவற்றுள் இந்நோய்க்கான மாற்று மருந்துவம் எது?

அ. இயற்கை எண்ணெய் பயன்படுத்தும் முறை

ஆ. மூலிகை மருத்துவம்

இ. இனமுறை மருத்துவம்

24. கீழ்க்கண்டவற்றுள் எது இந்நோயினை ஊக்குவிக்கும்?

அ. இரத்த அழுத்தம்

ஆ. சர்க்கரை வியாதி

இ. காசநோய்

25. வயதானவர்கள் எவ்வளவு நேரம் இரவில் தூங்கவேண்டும்?

அ. 8 மணி நேரம்

ஆ. 5 மணி நேரம்

இ. 9 மணி நேரம்

விடைகள் குறிப்பு

கேள்வி எண்	விடை	கேள்வி எண்	விடை
1.	a	14.	c
2.	a	15.	c
3.	a	16.	a
4.	c	17.	b
5.	a	18.	a
6.	a	19.	b
7.	b	20.	a
8.	c	21.	c
9.	a	22.	b
10.	a	23.	a
11.	b	24.	a
12.	b	25.	a
13.	a		